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ABSTRACT

This document describes a practicum designed to address the needs of the parents of children who have experienced extrafamilial sexual abuse. It notes that, in cases of extrafamilial child sexual abuse, services are directed toward the child and that the neglect of the parents may exacerbate the child's stress. The practicum is aimed at: (1) increasing parents' knowledge of myths about child sexual abuse, sexually abusive behavior, behavioral indicators of child sexual abuse, and effects of sexual abuse on family members; (2) understanding how parental reactions to child sexual abuse affects parents and families; (3) giving parents an opportunity to express feelings about the abuse; (4) building parental self-esteem and competency by learning child behavior management and safety strategies; (5) reducing parental stress and increasing coping skills; and (6) decreasing parental sense of being alone. The 8-week Parent Program developed and implemented to meet these goals is described. Evaluation results are discussed in which 100% of program participants responded affirmatively to almost every goal. The intensity of the group process and the unwillingness of the parents to separate at the practicum conclusion are indications of a need much greater than originally anticipated. The report concludes that the self-directed continuation of the parent group confirms that treatment must recognize the needs of both child and parent victim. The program curriculum and related materials are appended. (Author/NB)

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PRACTICUM REPORT

Center for the
Advancement of Education
Ed.D. Program

Increasing Parent Knowledge of Extra-Familial Child Sexual Abuse Through Development and Implementation of a Parent Program

By

Barbara Susan Bernbaum

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Increasing Parent Knowledge of Extra-Familial Child Sexual Abuse Through Development and Implementation of a Parent Program

by

Barbara Susan Bernbaum

Cluster 19

A Practicum Report Presented to the Ed.D. Program
in Early and Middle Childhood
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Education

NOVA UNIVERSITY

1986

PRACTICUM APPROVAL SHEET

This practicum took place as described

Verifier: Barbara A. Mara, Ph.D.

Director of Psychological Services

Winter Park, Florida

January 12, 1987
Date

This practicum report was submitted by Barbara Susan Bernbaum under the direction of the adviser listed below. It was submitted to the Ed.D. Program in Early and Middle Childhood and approved in partial fulfillment of the requirements for the degree of Doctor of Education at Nova University.

Approved:

February 27, 1987
Feb. 27, 1987
Date of Final Approval of Report

Polly Peterson, Ph.D., Adviser

DEDICATION

- To Those Parents Who Had The Courage -

- To My Family Who had The Patience -

TABLE OF CONTENTS

Page

PRACTICUM APPROVAL SHEET. ii

DEDICATION. iii

TABLE OF CONTENTS iv

LIST OF TABLES. vi

LIST OF APPENDICES. vii

ABSTRACT. ix

Chapter

I INTRODUCTION. 1

The Work Setting and the Author. 1
The Community. 4

II STUDY OF THE PROBLEM. 7

Statement of the Problem 7
Documentation of the Problem 9
Analysis of the Problem. 15
Related Literature 17

III ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS . . . 24

Statement of General Goals 24
Specific Objectives. 24
Description of Evaluative Instrument and
Standard of Achievement. 25

IV SOLUTION STRATEGY 28

Possible Alternative Solutions 28
Solutions Selected 48
Steps to be Taken. 53
Report of Action Taken 55

Continued

Page

V RESULTS, CONCLUSIONS, AND RECOMMENDATIONS 74

Results. 74
Conclusions. 112
Dissemination. 119

REFERENCES. 121

APPENDICES. 126

LIST OF TABLES

Table		Page
1	Parents' Rating of Degree of Violence Used in Sexual Abuse.	77
2	Parents' Rating of Degree of Sexual Contact Used in Sexual Abuse.	77
3	Parents' Rating of Increased Stress Due to the Sexual Abuse of Their Child.	79
4	Parents' Rating of Positive Feelings About the Manner in Which They Handled the Trauma of Sexual Abuse Since Disclosure.	82
5	Parents' Concerns About Effects of Sexual Abuse . . .	82
6	Objective 1: Meeting the Goals of Increased Knowledge of Sexual Abuse	88
7	Parents' Responses on Evaluation of Parent Program. .	111

APPENDICES

		Page
A	Parent Program Data and Questionnaire Form.	127
B	Informal Consent to Participate	132
C	Syllabus.	134
D	Parent Information Letter	136
E	Session I: Introduction, Definition of the Spectrum of Child Sexual Abuse	139
F	Session II: Myths of Sexual Abuse and Sexualization of Normal Developmental Issues.	149
G	Sexual Abuse Questionnaire.	156
H	Handout: Mothers Against Drunk Drivers.	159
I	Handout: Sunny von Bulow Victim Advocacy Center	161
J	Session III: The Effects of Sexual Abuse on Child/ Parent/Family	164
K	Signs of Child Sexual Abuse	171
L	Session IV: Parental Responses.	176
M	Handout: Tips to Help Parents Cope.	185
N	Session V: Discipline that Develops Responsibility and Parent-Child Communication.	188
O	Handout: Goals of Misbehavior	194
P	Handout: Goals of Positive Behavior	196
Q	Handout: Engaging a Child's Cooperation	198
R	Handout: Quick Reminders for Effective Communication with Children	202

Continued

		Page
S	Session VI: The Use of Time-Out and Behavioral Contracts	205
T	Handout: Using Time-Out for Behavioral Problems	208
U	Handout: Behavioral Contract	215
V	Handout: Behavioral Contract (Joint)	217
W	Session VII: Protecting Your Child	219
X	Session VIII: The Final Session	231
Y	Parent Program Assessment and Evaluation Form	233
Z	Letter of Request to Prentice-Hall, Inc	237
AA	Letter of Permission from Prentice-Hall, Inc.	239

ABSTRACT

Increasing Parent Knowledge of Extra-Familial Child Sexual Abuse Through Development and Implementation of a Parent Program. Bernbaum, Barbara S, 1986: Practicum Report, Nova University, Ed.D. Program in Early and Middle Childhood Development. Descriptors: Child Sexual Abuse / Parent-Child Relationships / Family Relationships / Family Problems / Parental Attitudes/ Parent Roles / Parent Reactions / Child Rearing / Problem Children / Parent Education / Family Counseling / Parent Counseling.

This practicum addressed the needs of the parents of children of extrafamilial sexual abuse. In a review of the literature and a survey of community resources, this writer found only one program offering combined services to both incest & extrafamilial parent victims. The orientation of both the literature and direct services was to focus on the child. The neglect of the parental victim has usually resulted in exacerbating the stress of the sexually-abused child.

This writer's goals were: (1) to have parents increase their knowledge of: a) myths about child sexual abuse, b) the spectrum of sexually abusive behaviors, c) behavioral indicators of child sexual abuse, d) effects (physical, emotional, and social) of sexual abuse on the child/parent/family; (2) to understand how parental reactions to the sexual abuse of their child affects both themselves and their families; (3) to have an opportunity for parents to express their feelings about the sexual abuse of their child; (4) to build parental self-esteem and competency by learning new strategies related to child-behavior management and child safety; (5) to reduce parental stress by learning new adaptive behaviors and resource strategies for coping with stress; and (6) to decrease the sense of "being alone" as a parent of a child who has been sexually abused. In addressing these goals, the writer developed and implemented an eight-week Parent Program.

Of the parents who participated in the Parent Program, 100% responded affirmatively to almost every practicum goal. However, the intensity of the group process, plus the unwillingness of the parents to separate at the practicum conclusion, indicates a need much greater than originally anticipated. The self-directed continuation of the parents, as both support group and an advocacy group, confirms that treatment must recognize with equality the needs of both child and parent victim.

CHAPTER I

INTRODUCTION

THE WORK SETTING AND THE WRITER

Now in its seventh year of providing an extensive range of medical, psychiatric, psychological, consultation, and supervision services, this writer's multidisciplinary private practice office serves patients of all ages who are able to pay privately for care, as well as those patients in need of services and funded through the State Health and Rehabilitative Services (HRS) Program. Thus, patients are an interesting mix that ranges from the most affluent to the most needy.

Six years ago a drive, spearheaded by the professional staff, culminated in the opening two years ago of the first full-service inpatient psychiatric facility built in the area. The hospital offers treatment programs in geriatric psychiatry, adult psychiatry and chemical dependency, adolescent psychiatry and chemical dependency, and child psychiatry. The writer's office acts as consultants, therapists, and evaluators to all hospitalized patients.

Presently the office has once again expanded in an attempt to provide quality services not yet available in the area for

patients. A separate adolescent program has been created and is housed in a facility adjoining the office. At program completion, it will consist of a 12-month day-treatment program combining full academic and therapeutic services, a therapeutically-oriented recreational summer program, and an intensive precare/aftercare program designed to provide a bridge between the highly structured psychiatric inpatient setting and the relative autonomy of outpatient treatment. Services will be designed for both adolescents and their families.

The professional office staff includes four psychiatrists, three Ph.D. and Psy.D. clinical psychologists, a psychiatric nurse, four master level clinicians, and three master or doctor level interns. Two secretaries, a bookkeeper, a typist, and an office manager complete the clerical support staff. There are specialists in child, adolescent, adult, and geriatric psychiatry, forensic psychiatry, educational testing, pain and stress management, marital and family counseling, parent education, divorce mediation, an sexual-abuse evaluation and treatment. Individual, group, and family treatment is available.

Theoretically, the office operates from a biomedical/-psychological base. Office hours are Monday through Friday, 8 a.m. to 6 p.m. Clientele are referred to as patients. An interdisciplinary team approach is stressed. Staffings are held weekly with mandatory attendance by all professional staff. The

office brochure announces with great pride that "this practice operates as a team".

Philosophically, the office is committed to providing the most up-to-date, professional, ethical, and comprehensive services possible for all its patients. All staff has been professionally trained and are encouraged to continue their professional growth. Great pride is taken in the staff's professional capabilities.

A walk through the physical plant itself reveals a commitment to children. From the chalkboard play area in the waiting room to the two fully-equipped playrooms to the clinicians' private offices stacked with toys and games to a complete outside playground, there is evidence that children are welcome. It is because of this commitment to children that this author found her way to this office.

The writer has had a variety of professional experiences with children prior to this present position of mental health clinician. Previous to this position, for three years she was director of a day-treatment program. This program was a combined effort among mental health, HRS, and the local school system to meet the academic and therapeutic needs of 35 identified severely emotionally-disturbed youths. In this capacity as program director, this writer coordinated all necessary services among these three agencies, was responsible for all the daily workings

of the program, supervised five master level clinicians, provided consulting child psychiatric and medical services, held inservice training programs for all team members (therapists, teachers, and aides), provided family counseling and parent education when possible, and directed a high-interest summer school program to prevent regression of both academic and behavioral skills acquired within day treatment throughout the regular school year. All budgetary work, grant writing, and program reports were also this writer's responsibility. For the years prior to directing the day-treatment program, the writer was involved in two local mental health centers as a clinician with children's services, as well as teaching in the Emotionally-Handicapped Program in a local school district.

Currently, the duties as a mental health clinician include individual, group, family, and marital counseling for both children and adults, adolescent group facilitator, parent education, intake assessments, client medical monitoring, case management, patient referral and resource information, and consulting therapeutic services on the children's, adolescent, and adult units of the hospital.

THE COMMUNITY

The office's professional expansion has been reflective of the growth of both the entire state as well as the local area. The population has expanded by over four million between 1970 and

1984 to 10.9 million for a growth rate of 61%. By 1990, this state will be the fourth most populous in the nation, following only New York, California, and Texas. The area in which the office is located is comprised of three counties and its population has increased by 79.9% during the same period. This population growth is projected to continue well into the next century. As the Chamber of Commerce states in its brochure, "Long noted for its natural scenic beauty, its central location and mild climate have proven to be especially attractive to residents and a broadening economy".

The economy, although originally sustained through citrus and agriculture, has now expanded to include these and other industries such as electronics, manufacturing, distribution, and tourism. A projected 145,000 new jobs will be established by 1990.

An explosive population growth brings with it a growth in human-service needs. The Information and Referral Center, a department of the Human Services Council, is a service provided for residents of the tri-county area.

A guide compiled by the Information and Referral Center and published as a community service by United Telephone Company lists a myriad of human-service agencies under the following headings: Adoption Agencies, Alcohol Treatment and Education, Animal Services, Child Care/Education, Community Planning,

Consumer Information and Protective Services, Housing-Emergency, Legal Services, Meal Services, Crisis Intervention, Disaster Services, Drug Abuse Treatment and Education, Herpes, Housing, Medical Support Groups, Mental Health Services, Poison Control, Pregnancy/Family Planning, Recreational Programs, Senior Citizen Services, Shelter - Temporary, Spouse Abuse, Transportation, Unemployment Compensation, Veterans' Service, Volunteer Services, Women's Programs, Workers' Compensation, and Youth Services.

CHAPTER II

STUDY OF THE PROBLEM

STATEMENT OF THE PROBLEM

Within the office, a team of child clinicians called "The Child Study Team", headed by the Director of Psychological Services, works together in consultation, evaluation, and treatment of sexually-abused children. To date, the Director has seen more than 500 sexually-abused victims as well as offenders. This multidisciplinary team approach, plus the use of a standard evaluation packet, helps the clinicians dealing with these difficult cases and lends more objectivity to any type of final evaluation report. All evaluations are based on a developmental approach.

In attempting to cope with the stresses caused by the crime, parents who are suddenly confronted by the professional confirmation of the sexual abuse of their child are traumatized. There is ignorance regarding the etiology of sexual abuse and confusion regarding the effects on their child, themselves, and their families. They have not yet begun to appreciate the stress that this particular crime, the system, and the consequences of victimization impose. The author, as well as the other health-

care professionals in the office, can provide the important services of both identifying and treating the parent-victims' needs. Yet there is neither policy nor programs within the association to direct these victims for appropriate assistance. Only individual psychotherapy can currently be offered as an option.

It is agreed upon by all the professional staff at the office, as well as recognized within the large body of family-systems professional literature, that no child stands separate from his family. Therefore, parental reactions to the sexual abuse play a large role in shaping both the child-victim's responses and adjustments to the trauma. Often parents, in their attempt to deal with the trauma, incorporate inappropriate styles and coping methods. The results are often a more stressed and dysfunctional child and family, thus exacerbating the sexual-abuse situation on all its victims.

The clinicians themselves are often hampered in their work with the child because of parental needs and emotions. Continuous requests from these parents for "just a few minutes" of the clinician's time or an endless stream of telephone calls take away from desperately needed one-on-one time with the child victim. The professional staff is continuously in conflict about which victim's needs to fulfill.

Although some positive results are evidenced initially in

therapy, these will not be sustained without continuous therapeutic intervention. Parents do not understand this, so they look at initial improvements as evidence that all is well and take their child out of therapy. Without this support and knowledge, without having their own needs met, the long road back becomes frustrating for parents and they withdraw. Parents, children, and families will most likely be further impaired and the professional is rendered both useless and helpless.

During individual interviews, the four clinicians expressed frustration with their limited ability to offer these parents any comprehensive treatment. Yet, simultaneously, they all felt gratified about their work with the sexually-abused child. Knowing that one cannot provide therapeutically "all things to all people", The Child Study Team has first by interest and now by reputation oriented itself specifically to the assessment and treatment of the child victim of sexual abuse. Limited professional human resources, personal commitments, and interests in other clinician areas have prevented the expansion of sexual-abuse treatment within the office to include the parental victims.

THE PROBLEM REMAINED THAT TREATMENT SERVICES WERE NOT AVAILABLE FOR PARENTS OF THE EXTRAFAMILIAL SEXUALLY-ABUSED CHILD.

DOCUMENTATION OF THE PROBLEM

The results of individual interviews with clinicians who

evaluate sexually-abused children at the office, a parent victim, and a high school counselor were used to obtain specific examples indicative that a problem existed.

Information gathered from interviews at the office indicated clinicians who can best be described as frustrated. In each interview, there was a commonality of helplessness felt by the clinicians who were unable to direct parental victims to a "comprehensive treatment modality", a "finite program" designed especially for them.

This writer, through community research for this practicum, became aware that there is a support group in the community for parents of extrafamilial sexually-abused children. Only one other clinician was aware of its existence and believed erroneously that it was a mixed group of parents of intra- and extrafamilial sexual abuse. This left clinicians able to offer only individual psychotherapy within the office or a referral to the local mental-health office for similar services. One clinician directs these parents to local sexual-abuse programs clearly designed for the incestuous family. With full realization that this is an inappropriate referral, she stated, "Maybe they can pick up some information or support that might be helpful. I feel better at least directing them somewhere."

The clinicians all acknowledged that parental follow-through in seeking treatment for themselves was almost negligible. The

lack of an appropriate program, finances, and dysfunctional coping responses were believed to be some of the reasons why this occurs. One therapist believed that, in an attempt to deal with their rage and gain back mastery over their lives, these parents try to pull the child back into self and consequently try to regroup the family as it was before the trauma. Outsiders, that is, the professionals, are not welcome. Another clinician believed that parents did not seek treatment because of parental denial that treatment is necessary either for the child or themselves.

However, many parents do acknowledge, seek out, and encourage professional help for their child. Clinicians felt often parents unconsciously attempt to deal with their own emotions through their therapized child. The most frequently used method is the parent who asks for "a few minutes" of the clinician's time before their child's therapy appointment. Or the telephone message asking for a return call "because of a problem" regarding their child. Those "few minutes" and "the problem" often turn into mini-therapy sessions for the parents. The clinicians, aware of the parents' emotional needs, reported feeling stressed and frustrated that they had to take from the child's therapy time to support the parents who themselves needed to be in treatment. All seemed to agree that denial, anger, and guilt were the most common parental responses.

A local high school counselor was contacted by this writer for any experiences she may have had with extrafamilial sexually-abused children and their parents. She told this writer of two 10th grade females who came to her office one morning. One girl said that her friend had been in the bathroom crying and was simply unable to go to class. She had finally coaxed her to come to the guidance counselor to talk.

The guidance counselor reported that she does not recall the presenting problem that first day, but she did establish rapport with the student and gained a commitment to come in weekly and talk. Approximately three months later, during one of these sessions, the student broke down and confided to the counselor that she had been raped in the 7th grade by a man who offered her a ride while she was hitchhiking home from school. She had never before told anyone. The guidance counselor worked with the student until she was comfortable enough to bring in her parents and discuss the issue.

When the student told her parents of the rape, the guidance counselor said she could almost see the parents becoming "nauseated". The mother's response was one of hysterics while the father became silent "as if in shock". Both parents asked why their daughter had never told them. She responded that she knew her parents had warned her repeatedly of the dangers of hitchhiking and she simply did not want to get into any more

trouble.

Very quickly, the parents became supportive of their daughter and realized that her not being able to tell them was indicative of a larger family problem. They left the guidance counselor's office with the names of three family therapists. The student continued weekly visits with the guidance counselor until the school year ended. For the first time, she was beginning to realize that many of her sexuality problems and family estrangement issues were directly related to her rape. In a follow-up call to the parents, the mother reported to the guidance counselor that much family progress had been made through family therapy. Yet something, she felt, was missing. "How do other mothers feel who have had a daughter raped?" She asked the guidance counselor to refer her to a group where she might talk with other parents. The counselor had to tell her that, to her knowledge, no such group existed.

Perhaps the most relevant of all documentation comes from the targeted population--the parents. The following is a story of one parental victim as shared with this writer in an interview for practicum documentation purposes. This was the second time this writer had spoken to this mother. The first was a year ago (August 1985) when she brought her 3-1/2 year-old daughter to the office for a sexual-abuse evaluation in conjunction with allegations of molestation against a male neighbor. It was these

parents who made me realize the absence of services for parental victims of extrafamilial child sexual abuse within our mental-health community. This practicum is a response to their unmet needs.

Only the mother was available for interview and she was most willing to bring this writer up to date on her family one year later. She began by saying, "It is still a part of our daily lives and never seems to leave us. He (the perpetrator changed the course of _____'s life, ours, and our families. I'm still frustrated and angry that it seemed then, and still does now, that there was no one for her and no one for us."

She reminded me that she herself had been raped as a child. Her daughter's trauma keyed her own pain and sent her back to her therapist for six more months of individual therapy. She believed this was one of the reasons why she had been excessively emotional over this issue. Her husband had remained more stoic and "seems to have internalized and repressed his anger. Our different responses caused, and still causes, much tension between us."

The sexual evaluation done at this office indicated that their daughter had been sexually abused. However, both their lawyer and the police felt that, due to a number of factors, prosecution in the case would be almost impossible. They suggested that their daughter not be traumatized further by a

legal process which would most likely not rule in their favor. Beset this past year by financial difficulties as well, the family has not been able to change their residence. With no interventions legally and no resources financially, these parents are faced with seeing the perpetrator almost daily. The mother said, "I spend my time making sure our daughter doesn't come in contact with him. But how much longer can my luck hold out?"

When this writer asked directly about her daughter, the mother's voice saddened. "Her personality has changed over the year. She's become an angry child and seems to hold things to herself. She used to be such an easy-going child." A concern was expressed for their oldest daughter who, at seven, was the one to report her sister's abduction from their backyard. "Shouldn't she be in therapy? She's different now, too!"

This mother encapsulated the reason for this practicum when she said, "Please put our names at the top of your list. We desperately need the kind of group you're going to begin. You know the best thing we as parents can do for our daughter is to be resolved about the issue ourselves."

ANALYSIS OF THE PROBLEM

At this time, several problems had become apparent. The most obvious problem was simply a lack of clinical time and/or personal commitment towards developing treatment programs for parents of the extrafamilial sexually-abused child. Often

treatment programs are reflective of the psychological or philosophical theory upon which the clinician's personal bias resides.

Within this writer's commutable geographic distance, there is a lack of academic and professional training programs that enable practitioners to both learn and use a family-systems orientation. It would be within the parameters of this theory that the entire family would be viewed and ultimately treated as the victim in extrafamilial sexual abuse (Tolson, 1981).

Another cause of the problem is the lack of understanding by parents about the demands that the crime, the system, and the consequences of victimization impose. Without the cooperation of victims, our judicial system is unable to hold criminals accountable. Yet the President's Task Force on Victims of Crime acknowledges that victims find little protection within the system. Instead, they are treated, according to the Task Force, with "institutionalized disinterest". Victims are confronted with another brutality--to be blamed and used and ignored by those expected to help (Silverman, 1978).

The financial cost of obtaining therapy services is another contributing cause of the problem. If personal funds are available, they are almost solely designed for the child victim (Craft, Epley and Theisen, 1980). Limited funds, plus the parental belief that help for themselves would be an indulgence

and not a necessity, prevent parents from requesting treatment. If there are no demands for services, there will be no services offered.

At both the state and federal level, there is funding available to help the innocent victim recover from victimization (Crompton, 1980). Congress has enacted legislation to provide federal funding to assist state crime-victim compensation programs. Thirty-six states and the District of Columbia now have such programs (President's Task Force on Victims of Crime, 1982). However, many states do not advertise program availability for fear of depleting available resources or burdening numerically inadequate staff. Burdened by a multiplicity of administrative problems, divided by philosophical differences, and sorely lacking in funds, this program barely provides for the assaulted crime victim. Although one must commend efforts that finally begin to meet victims' needs, it is not possible at this time to fully address all the problems that persist (Germain, Brassard, and Hart, 1985). The extension of financial aid to other family members is impossible. As a result, parents are once again left without the financial resources necessary with which to secure adequate treatment.

RELATED LITERATURE

Research in the area of sexual abuse is filled with data about every aspect of child sexual abuse. If one looks more

specifically at the literature which relates to treatment for the victims of sexual abuse, we see a focus towards the child. It is the child who is identified and addressed almost uniquely as the victim. While in no way disqualifying the importance of this orientation, Finkelhor (1979), in dealing with sexually-victimized children, reports that no child stands neither alone nor apart from his family. Therefore, for every child victim of sexual abuse, there is also a victimized family.

Current sexual-abuse literature acknowledges this family-victimization orientation but almost exclusively in the area of intrafamilial sexual abuse--incest. Indeed, incest itself has been raised almost to its own separate but equal place within the sexual-abuse literature. "In discussing sexual abuse, there is a tendency to treat incest as a completely different subject" (Kempe, R., 1984). Our obsession with incest is well noted in the literature as stemming from the fact that "incest violates one of the most tenaciously maintained taboos in most societies" (Kempe, R., 1984). The result of this fascination is a myriad of professional literature which addresses the needs of its victims. In incest, the victim is clearly acknowledged and identified as all the members within the family unit. Thus more recognition is given to the other victims (and perpetrator) in incest.

Within the extrafamilial sexual-abuse syndrome--one or more unwanted sexual experiences between any adult person unrelated by

blood or marriage and a minor child, from exposure to rape--there is little in the literature which relates past child victim or child perpetrator (Kempe, C., 1983). Recent data obtained from a random sample of 930 adult women revealed that 31% reported at least one experience of extrafamilial sexual abuse before the age of 18 years (Paul, 1984). Such experiences may constitute 30% to 50% of all adult-child contact (Russell, 1983; Finkelhor, 1979). They are, however, less likely to come to the attention of child protective workers and therefore may well be underrepresented in samples from these agencies. Data also confirmed that children who are sexually abused outside of the family are abused in a significantly more serious manner. The magnitude and severity of extrafamilial sexual abuse indicate clearly that a significant number of children and parents are being victimized by this syndrome.

Within the literature, parents were often acknowledged as an important part of the sexual-abuse problem but in only two ways. First: "There appears to be two distinct therapeutic tasks required in this situation. One is to help the victim get back to normal as quickly and comfortably as possible. The other job is the preparation of the family for supporting the victim" (Figley and McCubbin, 1984). Second: As David Finkelhor reports on the implications of a 1981 sexual-abuse survey of 4,344 Boston households undertaken by the Center for Survey Research of the

University of Massachusetts, "all this evidence points to the need for more parent education on the problem of sexual abuse. The study findings also point to a need for educating parents about the handling of sexual-abuse incidents" (Finkelhor, 1984).

The paucity within professional literature dealing with parental needs during this time attests to the double victimization of these parents. Victimized by the trauma of having their child sexually abused and victimized by a society whose orientation at this time lends itself primarily in the direction of the child victim, Finkelhor (1979) states that intricate patterns of individual and family reactions to traumatization attest how profoundly a disaster which strikes one family member can affect the entire family. Unless we also begin to assertively deal with the needs of the parental victims within extrafamilial sexual abuse, as well as the child's, we will never fully achieve the minimization of the traumatic impact on the child victim.

Although much has been learned about sexual-abuse victims in the past ten years, the literature review highlights that little attention has been directed towards the parents of those extrafamilial sexually-abused children. There have been services noted by Finkelhor (1984), R. and C. Kempe (1984), James and Nasjleti (1983) that have indeed geared themselves to both the child and the parents, but these have been crisis interventions

to relieve the immediate stress for both child and family. But it is comprehensive treatment that is essential to any adequate treatment program for child sexual abuse (Luther and Price, 1980). "Occasionally, there are reported improvements that begin during a crisis but, without continuing help, they may be fleeting. If the changes are to be integrated, it is important that they be supported and that services to the family are not withdrawn at that critical point" (Helfer and Kempe, 1979).

Viewing the family as a whole and attempting to provide care that is balanced between parental need and child need is a difficult challenge. Within the literature there are described both a consortium of programs and a variety of services which attempt to meet the needs of both parent and child victims. In this writer's opinion, the literature has not yet presented a comprehensive way of meeting that challenge.

The family is the strongest and most important support system of the child. But "child and parental reactions to a sexual-abuse incident constitute a complex and transactional process where each mutually influences and, to some degree, determines the other" (Stuart and Greer, 1984). Treatment must recognize with equality the needs of both parent and child.

Yet child sexual abuse is a relatively recent topic for both research and treatment. The shame and secrecy that surround it have made sexual abuse not an easy problem to study. Many

individuals studying this problem do not all come from the same discipline (Finkelhor, 1986). Therefore, there has been no accepted consensus about methodology, effect, and treatment.

Most researchers agree that family reactions become in many aspects even more critical to the child's mental health and well-being than the abuse itself (Kudushin and Martin, 1981). But in the investigation of child abuse, the assessment of parental-victims' needs becomes particularly problematic, for it is impossible for parents to respond as unbiased to the sexual abuse of their child.

One parent who seems oriented to expect trauma may respond emotionally to a trauma where it does not exist. Guilt-related denial may cause another parent to overlook or minimize their affectve responses to the sexual abuse of their child (Finkelhor, 1986). These concerns must not be seen, however, as arguments against assessment procedures for the parental victims. Instead, the investigator must be sensitized and must take precautions not to further traumatize these victims.

But often the professional neglects the parents, leaving them without much-needed support, both at the time of the trauma as well as during recovery. In turn, then, this exacerbates the stress of the sexually-abused child (Elkind, 1982). It is imperative that comprehensive treatment be developed and implemented for the parental victims. It is through this

treatment that the major consequences for all sexual-abuse victims may be lessened--both during the time of trauma as well as throughout the rest of their lives. This is the way that the ultimate goal - safety and security for the child - will truly be achieved.

CHAPTER III

ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS

STATEMENT OF GENERAL GOALS

The goal of this practicum was to facilitate for parents of the extrafamilial sexually-abused child an understanding that the sexual abuse of children is recognized as a major problem with consequences for both children and their families.

Information regarding sexually-abused child-victim reactions, parental-victim reactions, dysfunctional coping methods, and resources for coping with parental stresses enabled parents to more effectively facilitate communication and empathy among all family members, both in terms of their own needs as individual victims in crises as well as their ability to support each family member through the trauma.

SPECIFIC OBJECTIVES

At the conclusion of the project, it was expected that the parents would be able to indicate evidence of having met the general goals of increased knowledge of sexual abuse and application of that knowledge within their families by meeting the following specific objectives:

1. To have parents increase in their knowledge of:

a. Myths about child sexual abuse.

b. The spectrum of sexually-abusive behaviors.

c. Behavioral indicators of child sexual abuse.

d. Effects (physical, emotional, and social) of sexual abuse on the child/parent/family.

2. To understand how parental reactions to the sexual abuse of their child affects both themselves and their families.

3. Have an opportunity for parents to express their feelings about the sexual abuse of their child.

4. To build parental self-esteem by learning new strategies related to child-behavior management and child safety.

5. To reduce parental stress by learning new adaptive behaviors and resource strategies for coping with stress.

6. To decrease the sense of "being alone" as a parent of a child who has been sexually abused.

DESCRIPTION OF EVALUATIVE INSTRUMENT AND STANDARD OF ACHIEVEMENT

The recruiting of this parental population into a willingness of involvement in the practicum was for this writer an initial standard of achievement. Parents' attitudes about agencies, professionals, and therapists are often suspicious (Fritz, 1986). Fritz further states that parents have deeply ingrained fears about treatment. They believe they will be labeled as "sick" or "crazy" if the seek services in a mental-health clinic. Even if

the interaction of these parents into a group was achieved, this writer had concerns lest these same fears handicap group members in their ability to trust--and therefore share with each other.

During the first Parent Program session, the 11 participating parents were asked to complete the Parent Program Data and Questionnaire form (Appendix A) devised by this author. This form solicited information in three domains: parental demographic information, information specific to the sexual abuse of their child, and affective parental responses to the sexual-abuse trauma.

The form consisted of 36 items. This tool was representative of an inventory type objective paper-and-pencil test. The parents were asked to assess through a combination of forced-choice response, as well as free-response their answers to the 36 items.

At the last of the eight weekly sessions, parents were asked to complete a Parent Program Assessment and Evaluation form (Appendix X) also created by this writer. This instrument was used to assess whether parents had met both the general goals of increased knowledge of sexual abuse and its application within their families as well as previously stated objectives.

This form was also used by this writer to determine the success of the parent sessions. Parents were asked about program content and what new topics should be added to future programs.

Suggestions for change and improvement in the organization and format of the series were encouraged. Participants were asked if they would be interested in attending other programs. This form was distributed, collected, and evaluated by this writer.

Via audio taping done during the eight weekly sessions, anecdotal information was gathered and used as additional material in the assessment of this practicum.

CHAPTER IV

SOLUTION STRATEGY

POSSIBLE ALTERNATIVE SOLUTIONS

This writer was unable to find within the professional literature one program which addressed detailed treatment for the parents of the extrafamilial sexually-abused child. There were in the literature sources such as O'Brian (1983), R. and C. Kempe (1984), Finkelhor (1979, 1984), Figley and McCubbin (1984), and others who did incorporate parental involvement and data. In reviewing these sources and others, there are at least four areas which must be considered when attempting to address the need of the parent-victim: child-victim reactions, parental-victim reactions, dysfunctional parental coping methods, and resources/strategies for families coping with stress (MacFarlane and Waterman, 1986).

CHILD VICTIM REACTIONS:

Ruth Kempe (1984) reports "That variables must be considered when talking of the results of sexual abuse of children, variables which make important differences in their effect upon the child immediately or overtime". These variables are:

1. How the act itself is perceived by the child: as

confusing, frightening, painful, pleasant, or exciting.

2. The nature of the nonsexual relationship between child and offender.
3. The ability of the child to understand the significance of this relationship due to age and developmental level.
4. The response of the child's family and others to the sexual abuse if the child reports it or if it is discovered.

Victims, therefore, reacted to their sexual experiences in different ways. Most were negative but some were positive (Finkelhor, 1979). At least two authors, Groth (1978) and MacFarlane (1978), are reported by Finkelhor to have formulated assumptions for these differences. Four factors which they found that increase trauma of sexual victimization for both child and parents are:

1. The closer the relationship between the child and the older partner, the greater the potential trauma.
2. The longer the experience goes on, the greater the harm.
3. More elaborate kinds of sexual activity result in more trauma, actual penetration being the most, and simple exhibition without physical contact being the least traumatic.
4. Experiences involving aggression are likely to be the most negative. Parents must be reminded that, in

evaluating the impact of sexual abuse on the child, "we are dealing with children's sexual experiences, not adults', and that we (adults) may need different framework" (Finkelhor, 1979). Therefore, parents cannot expect that their child should or would respond in a certain way to the trauma because of what they assume would be their own feelings to the issue. Yet there is substantial consensus among clinical literature that the effects of sexual activity on children can be identified through the realm of physical, emotional, and social. These are both short-term and long-term results. The Texas Department of Human Resources (Select Committee on Child Pornography, 1978) reported these short-term effects on a child involved in sexual activity:

a. Regressive behavior.
b. Delinquent behavior.
c. Sexual promiscuity.
d. Poor peer relationships.
e. Unwillingness to participate in physical or recreational activities.
f. Running away.
g. Drug and/or alcohol abuse.
h. Confusion.
i. Depression.
j. Anxiety.
k. Suspicion.
l. Bad dreams.
m. Restlessness.
n. Inexplicable medical problems.
o. Self-mutilation.

From some of the more general studies (Lindberg and Distad, Lynch and Roberts, 1981, 1985), know that some long-term

reactions include bouts of depression and confusion about sexual identity. Some victims feel singled out or stigmatized. Some have suicidal tendencies. O'Brian (1983) states in some cases the personality and behavior of the victim has been influenced to include the repetition of self-destructive patterns, such as drug or alcohol abuse, self-mutilation, and the development of frigidity. He also believes that it is likely that sexual exploitation increases a child's susceptibility to exploitation by others.

The list of short-term effects presented by the Texas Department of Human Resources was prefaced with a plea for parents to become more knowledgeable of the signs of child distress in order to stop the trauma from becoming more harmful than necessary to the child. This writer believes this orientation must be broadened to also include that sympton awareness also facilitates parents in becoming more aware of which behaviors are appropriate developmentally and which ones herald more complex problems. To further assist parents in this understanding, Huchton (1985) recommends that parents be aware of the following signs of sexual-abuse behaviors as suggested by Doctors Avery and Yolanda Rodriguez-Escobar, specialists in child protective services with the Texas Department of Human Resources.

From birth through 3 years of age, a child may:

show signs of physical injury.

show signs of physical illness, possibly related to genital or urinary systems.

become unusually fussy.

refuse his/her favorite food.

exhibit a sudden or unusual fear of strangers.

show a lack of enjoyment in his/her favorite playthings.

cling to parents as if fearful.

experience great difficulty getting to sleep.

exhibit extreme fear of being left alone.

suffer from frightening dreams.

regress to an earlier pattern of behavior.

show a regression of skills.

experience a loss of his/her sense of security.

become unable to adjust to his/her normal schedule.

manifest any change from his/her normal behavior pattern.

<u>From age 4 through 12</u>:

exhibit signs of physical injury.

manifest signs of physical illness, with a variety of symptons from recurrent headaches, upset stomach, or urinary-tract infection.

exhibit sudden extreme shyness.

suffer from frightening dreams.

experience great difficulty getting to sleep.

refuse his/her favorite foods.

suffer from depression.

exhibit some loss of memory.

worry excessively, interrupting his/her normal life pattern.

exhibit a change in his/her level of scholastic achievement.

exhibit fear of specific adults.

have a sudden and unwarrranted fear of the dark.

exhibit extreme fear of being alone.

show a regression in patterns of behavior or skills.

exhibit a change in school relationships, including possible fighting and the sudden inability to adjust.

show a lack of enjoyment of his/her favorite TV shows, movies, games, or other activities.

seem easily distracted as though his/her mind is wandering.

manifest a change in his/her normal attitude.

manifest a change in his/her pattern of normal behavior.

act out in a sexual manner, appearing more knowledgeable about sex than his/her peers.

develop a pseudomature character, taking over specific parental responsibilities in the home (a sign predominantly associated with incest).

<u>From age 13 through 19, a teenager may</u>:

manifest signs of physical injury.

manifest signs of physical illness, headache, stomach cramps, urinary-tract infections.

suddenly refuse food.

suffer from sudden and violent frightening dreams.

manifest difficulty in getting to sleep.

seem in the depths of depression.

exhibit an inability to concentrate.

show irritability or manifest angry outbursts toward others.

exhibit a sudden and unwarranted fear of the dark.

have a sudden lapse of enjoyment of dating.

feel an unexplainable fear of being left alone.

worry excessively, interrupting his/her normal life patterns.

experience a loss of memory.

exhibit fear of specific adults.

exhibit a change in his/her level of scholastic achievement.

act out the sexual encounter with siblings or friends.

experience a lack of enjoyment for his/her favorite activities.

make an attempt to run away from home.

contemplate suicide.

appear passive or overly compliant in behavior.

behave seductively with the opposite sex.

manifest a deviation from his/her normal behavior patterns or attitudes.

It is this knowledge that can help parents feel more in control, more self-assured, and more responsibly involved in the encouragement of their children to return to a previous usual life style (Peck, 1982). This competency begins to offset parental feelings of inadequacy or irresponsibility for having allowed the child to go out and become victimized (Martin, 1976, 1984). It gives parents an immediate opportunity to actively begin appropriate, responsible parenting.

PARENTAL VICTIM REACTIONS:

The family is thrown into a state of crisis when sexual abuse comes to light. Family members may feel rage, hostility, guilt, confusion, and helplessness. Feelings towards the child also become complex, ranging from disbelief to blame. Family relationships become strained, even to the point of total disruption (Tollison and Adams, 1979). The child victim often comes to feel that he or she is responsible for the family's distress (Anderson, 1981).

Dr. Baker (1976) discussed the results of parental anger on professional staff. He found that most parents were very critical of the care provided by the hospital and its staff to their abused child. Although most parents were in agreement that the focus of professional concern should be for their child's injury and future safety, most admitted that they were extremely anxious about what would happen next, both to them and to their child. Resorting to verbal criticism and hostility was the only way these parents had of striking out in a situation in which they felt powerless and threatened (Blumberg, 1978, 1981).

Parents' own experiences as children, their relationship with their parents, their closeness to each other, and their own personal issues with sexuality are but a few of the dynamics involved in how individual parents respond to both the sexual-abuse crisis and their child (Burgess, 1985). It seems,

according to Figley and McCubbin (1984) that, "although the family's responses may be influenced by the stigma of the sexual abuse as well as the physical harm to the victim, generally the family's crisis arises from the victim's distress".

O'Brian (1983) believed that "the child's reaction cannot be separated from the family dynamics at the time the child is victimized". Research conducted by Stuart and Greer (1984) found children's worst fear is the loss of parental love and support. Therefore, parental reaction to sexual abuse plays a large role in shaping the child-victim's responses (Funk, 1980). It seems that parent-child reactions to sexual abuse may be bidirectional.

But the impact of the sexual abuse on the family is reported by both Figley and McCubbin (1984) and Stuart and Greer (1984) to cause the parents to move through stages of both shock and recovery in a manner similar to the victim's own experience. As a result, parents may exhibit specific emotional responses and symptoms that are typical catastrophic reactions.

1. Anger and Revenge:

A key factor which contributes to the emotional state of these parents is the intense rage directed toward the perpetrator. Historically, children (especially females) have been viewed as their father's property. This concept of "ownership" or of being "personally wronged" is often displayed by, as Silverman describes, "a property-holder's rage" (Figley

and McCubbin, 1984). Mothers may be struggling with feelings that she also personally has been violated. Mrazek and Kempe (1981) state, if the child was physically injured during the assault, that compounds the negative impact and increases the intense rage directed towards the perpetrator. This anger becomes both frightening and uncontrollable, resulting in a state of acute disequilibrium within the family (Ageton, 1985). Although thoughts of revenge may function to protect the parents against his own helplessness, "the victim, whose resources are already depleted, has to bear an extra burden of calming, placating, and reassuring those who would be her avenging protector" (Figley and McCubbin, 1984).

2. Helplessness:

Frustration builds in parents who are unable to "undo" the effects of sexual abuse on their child and themselves. Finkelhor (1984) presents that this loss of control over events leaves the parents grasping at random strategies in an effort to do something to relieve their frustration. Plotting revenge is one such strategy. Rallying the support of the victim's friends, clergy, teachers, and others is another. "Silverman (1978) suggests that this particular attempt by parents often is considered invasive or serves to humiliate the victim further as the trauma becomes public knowledge (Figley and McCubbin, 1984).

3. Guilt:

A review of the literature confirms that issues of self-concept or role expectation play a part in the manifestation of guilt by parents of victims who feel that they have failed in their duties as protectors (R. and C. Kempe, 1984, Figley and McCubbin, 1984, James and Nasjleti, 1983). Interpersonal parent-child difficulties and/or dysfunctional family patterns may either cause a child to place himself at greater personal risk or contribute to allowing the child to become an easier victim (Adams-Tucker, 1982). An example would be a female adolescent who runs away from home after a family fight and is raped. Parents experience considerable guilt and a sense of responsibility for the abuse. The "if only" feeling predominates and causes more parental guilt.

4. Blame:

Anger is often directed at the victim, manifested in blaming, doubting statements such as "Why weren't you more careful? "Didn't you realize what you looked like in that dress?" Dixon, Arnold, and Calestro (1978) have assessed that often emphasis is placed on the sexual aspects of the crime and not on the violence which the victim has experienced. Seldom, they say, are the victims given credit for escaping from the situation with their life (Burgess, Groth, Holstrom, and Sgroi, 1978).

5. Denial:

"Parental denial can take many forms, ranging from denial that the alleged incident took place, through refusal to believe the particulars of the abusive experience, to denial of the observable impact of the experience on the child. It should be stressed that almost all parents in these situations engage in some denial, however minimal" (Stuart and Greer, 1984). The underlying motivations or dynamics of denial or minimization have been shown by researchers (Finkelhor, 1979, James and Nasjleti, 1983, R. and C. Kempe, 1984) to be varied and complex. Causations range from a general maladaptive or non-supportive relationship between parent and child to a need to defend against one's own feelings regarding sexual violation. Mrazek and Kempe (1981) suggest that denial may reflect the parent's own inability to either cope with the stress of the situation or to constructively address their own anxieties and fears about the impact of the assault on the child. Minimization or denial by parents is most recognizable in the bypassing of the legal reporting system (Butler, 1978). Where Finkelhor (1984) reports in findings from the 1981 survey in Boston conducted by the Center for Survey Research of the University of Massachusetts that only a little over half the parents reported the sexual abuse of their child, this writer believes this is due in great measure to parental needs of denial and minimization.

DYSFUNCTIONAL COPING METHODS:

Ruth Kempe believes that in some forms of sexual abuse such as exhibitionism it may be the parent's pathogenic responses that are more damaging to the child than the abuse itself. In particular, she cites the overreactive histrionic parent who dwells unduly on possible dangers and markedly restricts the child's activities. Often these responses are parental efforts to mobilize strategies aimed at what parents perceive to be areas of concern for their child. These concerns as reported by Finkelhor (1984) are: development of emotional problems, fear of sex, fear of adults, and development of school problems. Even the outcome of least probability - that their child would become a homosexual - was expressed by a third of the parents (Finkelhor, 1984). The following are dysfunctional coping strategies parental victims use in an attempt to overcome these fears:

1. Patronization:

Parents may attempt to overcompensate for their own sense of guilt at what is perceived as their lack of protectiveness of the victim prior to the abuse. Hilberman (1976) suggests that new curfews may be enforced or children may have to be accompanied everywhere by either a parent or older sibling. Greengard (1982) states that the danger pointed out by research lies in the fact that this simply reinforces the sense of helplessness and dependence felt by the victim. The ability

to begin using adaptive coping strategies that would enhance self-esteem and autonomy are gone. Burgess, Groth, Holmstrom, and Sgroi (1978) concern themselves with the impairment of the normal developmental tasks of individuation and self-identity so necessary in adolescent development.

2. Distraction:

The "time heals all wounds" phenomenon is the underlying dynamic. If time goes by quickly and painlessly - which it might do with new gifts, vacations, fun-planned group activities - the child victim might skip over the trauma with a minimum of stress (Greengard, 1982). Playing down a victim's distress is not an unusual style for any parent who wishes to distract their child from pain. Helfer and Kempe (1969) strongly suggest that this denies the victim the opportunity for catharsis and mourning which may be necessary to move through the sexual-abuse trauma.

3. Protective Silence:

Perceived or believed stigma associated with sexual abuse often overwhelms parents. Projection (Mrazek and Kempe, 1984) into the child of these same feelings make parents presume that the victim is embarrassed or humiliated to talk about the trauma. Parents then cooperate in protecting with their silence. However, Hilberman (1976) discusses that the child victim interprets this protective silence as shame or disgust. "This

cycle of avoidance is unfortunate because of the need of all family members for mutual support and to work through the feelings precipitated by the abuse" (Figley and McCubbin, 1984).

Even with the best of intentions, coping mechanisms which the family may try to employ generally are reported by Ludwig (1981) to negate the victim's attempt at recovery as well as frustrate other family members. This results in increased interpersonal tension.

RESOURCES FOR COPING WITH STRESS:

The characteristics of families who best weather the stressful experience of sexual abuse are those that maintained a healthy family evironment prior to the crisis. This allows the family to be "a primary asset as a crisis-meeting resource" (Figley and McCubbin, 1984). R. and C. Kempe (1984), Finkelhor (1984), and Hilberman (1976), all suggest that the pre-quality of family relationships plus good communication skills, and role flexibility are attributes which tend to help families adapt to major disturbances more effectively.

1. Quality of Relationships:

The quality of family relationships prior to sexual abuse has been well documented in the literature as an important resource for the continuance of family stability and mutual support (Eberling, Hill, 1975). But the sexual-abuse trauma adds stress to vulnerable areas of family or parental relationships

which were unresolved at the time of the crisis. James and Nasjleti (1983) believe that these unresolved issues will most likely be intensified by the additional stress of the abuse.

Family members within a trusting supportive network will continue to count on each other for aide and nurturance in the midst of their trauma. Often this crisis can also serve to stimulate either a re-evaluation or a re-confirmation within the family of the quality of the relationships. An adolescent fearing rejection or blame by her parents may be surprised at the support and non-accusing stance by her parents (Giaretto, 1981).

2. Communication:

Ludwig (1981) confirmed that open communication within the family system is one of the most critical resources of the family. "Silverman (1978) felt that ventilation of feelings in a nonjudgmental environment would help family members realize their underlying negative attitudes toward the situation" (Figley and McCubbin, 1984).

Helfer and Kempe (1979) document that the welfare of the family is best served if blame and anger are recognized by all members and externalized to a source outside the family unit rather than toward one another. They do acknowledge that a delicate balance must be maintained for all family members between the need to ventilate negative feelings and yet offer support to one another. This writer would concur with Helfer and

Kempe on the difficulty of creating and maintaining that type of balance within the family but differ in their belief that "in the event that the family cannot reach a satisfying solution to their conflicts on their own, there are outside resources in most communities to which they can turn for help" (Helfer and Kempe, 1979). It is only through the alliance of the family and the professional from the onset of the trauma that will achieve the goal of family recovery and reintegration (Hochstadt, 1985).

3. Flexibility:

Both the child-victim's and the parent-victims' distress may prevent them from performing certain tasks or interacting with other family members as before the sexual abuse. In response to this role transformation, the family structure may change in terms of power, responsibility, interfamily dynamics, or economics (Luther and Price, 1980).

Clearly, then, the ease with which the family structure can realign roles during the recovery phase of the trauma will reduce the amount of conflict experienced in daily living. Rigidity of expectations towards each family member will often exacerbate the disruption of the unit as they attempt to function (Kroth, 1979).

The assessment of a family's coping abilities in extrafamilial sexual abuse is imperative as the first step in facilitation of the healing process. R. and C. Kempe (1984) assessed very accurately that this evaluation may require several

interviews. Talking with the child and his/her parents together will give an impression of the nature of their relationship. However, interviews also need to be separate, for both parents and children will present different responses when not in the presence of each other.

Oates (1982, 1986), Okrow (1985), and Pascoe (1979) suggest formats, styles, data-gathering techniques, and areas to be covered in this initial evaluation. What needs to be assessed using all this information is a picture of either a cohesive family surrounded by supportive friends and relatives or an isolated, fragmented family. These data are the base from which treatment begins to be formulated.

At the C. Henry Kemp National Centre for the Prevention and Treatment of Child Abuse and Neglect, with funding received through their victims' assistance fund, a parent-support group for parents of extrafamilial sexual abuse meets weekly. The focus is "to give parents an appropriate place to vent, explore, and resolve their own issues" (Kempe Center News, November, 1985). No program results were available to this author at this time for purposes of this practicum. This program will be presented at the International Meetings on Child Abuse and Neglect in Australia in August, 1986, and then results published in the International Journal on Child Abuse and Neglect.

For the past two years, a support group for parents of

extrafamilial sexual abuse has been in existence in this writer's community. This group was organized and is still primarily led by a victimized parental couple. A professional, master's-level social worker facilitates. Much valuable information was obtained by this author in direct personal interview (3/5/86) with this social worker.

Acknowledgement of the fragility of this group was a paramount issue. Even after two years, the group has an attendance of only five or six adults, with a central core of two consistent couples. The inability to recruit more parental involvement has been a frustrating reality. A multitude of attempts, from direct agency referral to home visits by the core couples, has not increased the willingness of appropriately identified parents to enter the support group. The dropout rate is also high, with the guesstimated length of attendance as three to four sessions. Parental guilt, anger at a failed system, denial, and fear of therapy are the main reasons believed to be causing lack of involvement. There is no fee charged for this parental-support group.

Ownership and control of the group were deliberately given to the parents as a response to their constant refrain of "You don't know how we feel!" The results, according to the social worker, is the development of "an open-ended and free-floating" group format. Each parental member leads the group on a weekly

rotation basis. This is not obligatory and any member may decline. The professional, although present during the entire group, "asks permission" to take the last few minutes of group in order to synthesize and clarify group feedback to its members.

That only these two couples have maintained group involvement is believed by the social worker to be directly related to the fact that these parents and their sexually-abused children are involved in both individual and family therapy within the agency. It is the social worker's belief that the therapeutic work done in individual and family therapy is the base which allows for a continuance of work within the group setting. Notable also is that it is the two married couples who have stayed with the group, while single parents have either refused to enter or have quickly dropped out.

The social worker felt that the format of this support group excels in offering victimized parents an opportunity to feel in control as well as much-needed ventilation of anger and frustration. What she felt was truly needed has not yet occurred: "That these parents had to be willing to cut through the trauma of the sexual-abuse experience and delve into their own investment of themselves as 'parental beings'".

In summary, this writer was unable to find either in a review of the professional literature or in practice a program that provided a comprehensive treatment solution that addressed the

specific needs of the parents of extrafamilial sexually-abused children.

SOLUTIONS SELECTED

The first step in providing a solution to the practicum problem was to enlist the help and support of the Director of Psychological Services. Results of this writer's preliminary literature review, telephone interviews with prospective parent particpants, and various solution strategies gleaned from the literature review were discussed. This information, coupled with the Director's commitment and expertise in the area of child sexual abuse, helped define an appropriate solution strategy.

This author was concerned that the non-directive loose structure of a parental support group would be in and of itself a major contributor of anxiety to some of the parents. A highly-structured didactic format with little demands for active participation from the parents would be less threatening, but this would not allow parents to either feel some control over the group sessions or for ventilation opportunities of their feelings.

It had become apparent during the telephone solicitations for group involvement that these parents were hungry for someone to talk with about the abuse. Initial telephone calls, which this writer had projected would be short, factual conversations regarding the upcoming parent program, turned into lengthy

communications. This writer became aware that these parents' emotional needs turned these phone calls into "therapeutic sessions". This writer began to legitimize issues brought up by the parents as concerns which were exactly the reason for the parent program. It was suggested by this writer that the parents write down their feelings or any questions to bring up in group.

This need to share and/or ventilate feelings made this writer wonder whether a structured didactic format would set up its own set of frustrations for the parents. Would they feel closed out? Two of the goals of this practicum had been defined as providing an opportunity for the parents to express their feelings about the sexual abuse and thereby decrease their sense of "being alone".

The best solution was to then prepare a series of semi-structured educationally-oriented group sessions. Each session would be split in half. First would be the information giving educational element of the practicum. By giving factual pragmatic information regarding sexual abuse, these parents would gain knowledge which would decrease anxiety related to the unknown issues within child sexual abuse. This would simultaneously increase the parents' feelings of being in control. The second half of each group would be in an interactional process for the parents themselves. This would be based more on a support-group model. This author would act as

group facilitator during this process. The parents could then feel free during the second half of the session to use the time as they needed. They could share family experiences, ask questions, or bring up any of their own personal issues, fears, or concerns.

Although this writer's office has extremely high credibility in both the lay and professional communities in the area of child sexual abuse, this writer had concerns whether enough parents could be recruited for a parent group. As discussed within the literature review, for a multitude of reasons, parents of sexually-abused children historically do not involve themselves in treatment modalities. This was further emphasized by the information gained in the personal interview with a local mental-health agency which had for two years been unsuccessful in their attempts to recruit and sustain a parent group.

Since topic submission for this practicum, this writer had been compiling a list of potential parents and community resources. Potential parent names came from this author's own case load as well as from other clinicians' in the office. In accordance with the American Psychological Association's guidelines regarding confidentiality, group participants for this practicum had to be contacted in a number of different ways. The parents of this writer's own clients were called directly by this writer. Referral names that had been gathered from other

clinicians within this author's work setting needed to be called directly by their own clinician. Each clinician was given a small fact sheet by this writer with all group information. These parents were encouraged by their clinician to participate in the group. The advantages for themselves, their sexually-abused child, and their entire family by their involvement were emphasized. If parents were interested in group participation, they were asked to contact this author at the office. Responses as reported back by the clinicians were extremely positive.

The first round of telephone calls for parental participation brought immediate positive responses. All parents voiced the opinion that this was long overdue. Most made it clear that, regardless of the day, time, or cost, they would be a participant. Two parents even offered their homes for the group meetings. Three parents who were unable to attend cited either babysitter, work-related, or previous commitments as the reasons asked that their names be put on a list and contacted again should a second group develop.

It was made clear to each parent contacted that their spouse, regardless of current marital situation, was also being asked to participate. A preliminary survey as to the most convenient meeting time was also taken during the initial telephone contact. Choices given to the parents were weekday, weekday night, or Saturday morning.

A contact person at each agency or private referral source was called by this writer. Information regarding the parent program was given on the phone and followed up the same day by mailing of a short fact sheet of program information directly to this contact person. This was to be circulated to any professional staff who might come in contact with potential group participants. Duplicate fact sheets, where appropriate, were enclosed for display on agency waiting room bulletin boards. Again in accordance with the American Psychological Association standards, any interested participant was asked to notify this writer at the office.

Although these telephone calls at times became both time-consuming and emotional, they provide invaluable in building rapport with the parents as well as networking within the local mental-health community. But, more importantly, these calls gave this writer valuable insight into the parents' present emotional state. This helped decide what content areas to cover in the parent group.

One idea that this writer's practicum reviewer suggested, based on her clinical experience with sexual abuse, was to expand the parameters of the group to grandparents. They, too, had become victimized by this trauma. This writer felt that this not only enhanced the concept of family education but also was most appropriate given family systems theory. Program participation

was then opened to both maternal and paternal grandparents of the child sexual-abuse victim. Unfortunately, no extended family members chose to participate in this particular parent program. One reason may have been that the opportunity for participation was never extended. Some of the parents responded unfavorably to this suggestion. One parent said, "I may be selfish, but I need something just for me!" Another said, "I wouldn't talk if my mother was in the group. I'd be too afraid."

It seemed clear, once this writer began the telephone calls, that parental recruitment would not be problematic. Parents were not only eager to be involved but wanted to be involved immediately.

STEPS TO BE TAKEN

The following schedule outlined the plan for designing, implementing, and evaluating an effective series of group sessions for parents of extrafamilial sexually-abused children:

1. Preplanning: May, June, July, August 1986

    a. Submitted both outline and practicum proposal for acceptance. Implementation was projected to begin September, 1986.

    b. Interviewed clinicians for documentation of problem existence.

    c. Met with Director of Psychological Services to review collected data and define which type of solution would be selected.

    d. Reviewed client files with appropriate clinicians and compiled a list of potential parents for group recruitment.

e. Personal telephone calls made by clinicians and this practicum writer to clients for possible group recruitment.

f. Developed parent program curriculum based on group objectives.

g. Met with Director of Psychological Services as often as was necessary and in the process of meeting (1) reviewed this writer's curriculum design, (2) reviewed methodology of data collection and evaluation procedures, (3) developed Parent Program Data and Questionnaire form (Appendix A), (4) planned specific group format. This included the length of group sessions, day group would be held, number of appropriate group sessions, group cost, etc.

h. Made personal telephone calls back to each parent who had previously committed to group participation with this author.

i. Drafted a letter of confirmation to parents (Appendix D). The purpose of this letter was to reinforce group commitment as well as a concrete and specific reminder of all information concerning the parent program.

j. Finalized plans for group meetings with office manager and checked that all resources were available and in working order.

k. Sent office memo with the parent program information to all professional and clerical staff as a reminder of group implementation and with specific group data.

l. Sent letter of group confirmation to all parents one week prior to first group meeting.

2. Implementation: September and October, 1986.

a. Eight consecutive weekly parent group sessions were held Wednesday evenings. All sessions were two hours in length (7:30-9:30 p.m.). All took place in Group Room of this practicum writer's office.

b. The finalized curriculum was typed and placed in the practicum final report (Appendices E, F, J, L, N, S,

W, and X).

c. Evaluated the results of Parent Program Data and Questionnaire form (Appendix A) completed by parents at first group meeting.

d. Developed and reviewed with Director of Psychological Services a Parent Program Assessment and Evaluation form (Appendix Y) to gather post-group data.

e. Wrote process notes on each group for practicum evaluation report. These notes were taken from the audiotapings that were made during each group session.

3. Results and Conclusions: November and December, 1986.

a. Analyzed all data collected.

b. Reviewed results with practicum adviser as well as the Director of Psychological Services.

c. Wrote up final report which included final results, conclusions, and recommendations.

d. Submitted final typed report.

REPORT OF ACTION TAKEN

A month prior to the projected first meeting of our Parent Program, this writer began a simultaneous two-track approach towards implementation of the practicum. One track was direct recruitment of parents for the group. The other, a series of meetings with the Clinical Director of Psychological Services to plan, review, concretize scheduling, review office policy and procedures, go over group format and curriculum content.

As active recruitment of parents continued, this writer met numerous times, both formally and informally, with the Director of Psychological Services. The use of facilities at this

writer's office for the practicum implementation had been approved on an unlimited basis. All office personnel, materials, and office space were made available to this writer per practicum needs. In keeping with office standards of record-keeping, one file on this Parent Program was to be kept among regular office-group files. This file would contain a weekly attendance sheet as well as short, ongoing, group process notes.

A fee of one dollar per session ($8 per family unit) was decided upon to help defray the cost of weekly supplies and refreshments. This writer hoped that even this small fee would help insure commitment to the Parent Group.

Much discussion between this author and Director of Psychological Services centered around data collection. Originally, an individual pre- and post-group semi-structured interview plus completion of the Parenting Stress inventory (PSI) had been projected. It was acknowledged that this interview time would be a useful tool to both help build parental rapport and gain valuable data regarding the sexual-abuse trauma. In addition, the PSI would be a clinically-objective measure of parental stress pre- and post-group participation. But this method of data gathering would exend parental commitment by at least an additional two trips to the office.

The Director of Psychological Services felt the PSI to be a test more appropriately used within the context of a practicum

which had a specific clinical orientation. This practicum is clearly designated as an educational practicum. It acknowledges the victimization of the parents, and its orientation states that increased knowledge (i.e., education) of the sexual abuse would increase parental ability to manage the trauma and decrease their stress levels.

This writer also became concerned that, since all participating parents had known of the sexual abuse for at least one year, they most likely were not in acute crisis and might not be as motivated to attend group. It was felt that asking parents to come to the office for a pre- and post-assessment session might result in less of a commitment to actual group attendance. Because of these reasons, it was decided to eliminate the personal interview and the PSI. Data would be obtained via the use of a parent questionnaire. When looking at data reported by parents Finkelhor (1984) stresses that some facts should be kept in mind. If the parent himself is the perpetrator, he would most likely not disclose that fact and, if the childhad been abused by a family member or close friend, parents may well withhold or minimize information about the abuse. On the other hand, children may not reveal any victimization to their parents or may also minimize for a myriad of reasons the extent of the abuse. Yet, despite all these limitations, it is necessary to see what parents do learn from their children and how they react.

The Parent Program Data and Questionnaire form (Appendix A) was designed by this writer and was given to each parent at the beginning of Session 1. The Parent Program Data and Questionnaire form solicited information in three domains: (1) personal parental demographic information (sex, age, marital status, number of children in family, occupation, work schedule, highest educational level obtained, salary range); (2) information specific to the parent's sexually-abused child (current age, age at onset of abuse, sex of child, relation of parent-participant to abused child, disclosure of sexual abuse, agency to whom abuse was reported, degree of violence, type of sexual abuse, relation of abuser to child victim); and (3) personal parental responses in regard to attitudes, feelings, and management issues relative to parenting the child victim of sexual abuse. (It must be stated here that, in accordance with Florida Statutes, every sexual abuse must be reported. If parents had not reported the abuse, this writer would have been mandated by law to report the incident.)

In keeping with the American Pyschological Association's professional guidelines, an Informed Consent to Participate form (Appendix B) was also designed. This release was reviewed with parents at the first session and all were asked to sign at that time.

A tentative curriculum for this Parent Program had been

slowly created by this author during the summer months prior to fall implementation. This was a time-consuming venture. Years of material accumulated by this author plus current information discovered during the practicum literature search necessitated an extensive review. Initially, materials were divided into four categories. These were: sexual abuse, parent-child communication, parental stress and anger, and child prevention and protection. This author then defined more narrowly the specific topics which were felt necessary and appropriate, given both subject matter plus specific practicum objectives. These topics were then prioritized and a first tentative syllabus was created. Although this author felt very well satisfied with the comprehensive scope of this first syllabus, its length seemed overwhelming. At one group session per week, this would have resulted in a Parent Program of 16 weeks. This author felt this was much too long a commitment for these parents.

The paring down of this first syllabus became the most difficult task to date in the practicum process. It was a difficult job to decide what to keep and what to discard. After another meeting with the practicum supervisor, it was decided that, although the content of the initial syllabus was relevant, it was probably twice as long as necessary. Some topics which this writer had wanted to spend two sessions on were concretized into one. Handouts were created to be used both as a vehicle to

disseminate information which needed to be cut but also as a reinforcing learning tool to augment the group lectures and discussions.

The final syllabus (Appendix C) contained seven topic areas and seemed to divide itself naturally in half. The first dealt with specific knowledge about sexual abuse and the second half was oriented towards a more active (self-help) parenting response to behavioral management. A final session was left open by this writer to cover material that may not have been covered or for review and wrap-up purposes. Thus the final syllabus for the Parent Program was to be eight weeks long.

The curriculum was presented to the parents in a series of one-time weekly sessions beginning September, 1986. Each session lasted two hours. Although originally scheduled from 7:00 to 9:00 p.m. every Wednesday for eight weeks, this time was changed from 7:30 to 9:30 p.m. at the request of the parents during the first group meeting. All sessions were held in the group room of this writer's professional office.

This two-hour time frame was felt by this author to be one where no formal break-time was needed. The split format already decided upon within each session created a natural break in the group process. To further help enhance this informal interactional process, coffee and refreshments were set up by this writer at the start of each session. Parents were

instructed at the first session to feel free to get their own refreshments as they wished throughout the evening.

Although referrals had been solicited from the entire community, most parent participants ended up having children who either were or had been clients at the office. One single mother was referred from Health and Rehabilitative Services. Another parent was brought to the program by a neighbor couple. This writer believes that the preexisting therapeutic relationship between parents and professionals was the key factor in the parents becoming participants. These parents had learned to either trust us or perhaps need us. Because of our work with their children, there was a feeling of security in the familiar environment and a sense of trust that what would happen at our group would be beneficial. A bond is created when one shares a trauma with others. The process of sexual evaluation and sexual-abuse treatment enhances that bond.

One week prior to the first group session, a follow-up letter (Appendix D) was sent to all parents who had committed to group participation. Purpose, goals, and group specifics were summarized.

Session I (September 10, 1986): Introduction of Program, Definition of the Spectrum of Child Sexual Abuse (Appendix E) began with this writer's reviewing for the parents the evolution of the Parent Program as the merger of a need as defined by my

professional work with the fulfillment of the requirement for my doctoral studies. This writer voiced appreciation to these parents for their courage and willingness to be part of the Parent Program.

Program objectives were discussed. The Informed Consent to Participate form (Appendix B) was handed out to the parents and reviewed. Each parent was assured that all responses would be held in strictest confidence and would be used only for research purposes. It was explained that audiotape recording was chosen as the method for preserving the information collected in group because it would eliminate the need for notetaking by this author as well as reduce the tendency of this writer to make an unconscious selection of data favoring my biases. Also tape recording would allow material to be analyzed by others as well as re-analyzed by this author. Each parent immediately signed the Consent form.

The program syllabus (Appendix C) was handed out. The importance of the commitment to group attendance was discussed. It was explained that only through a commitment on their part would this writer be able to learn how parents feel about having a child who has been a victim of sexual abuse.

The split-session format of one hour educational presentation and one hour group discussion was presented. The specifics of the group were reviewed. Cost of the group was discussed with

everyone either immediately paying cash or writing a check. Refreshments were pointed out and parents were encouraged to help themselves as there would be no formal break during our two-hour session.

General group objectives were reviewed by this writer with the parents. To help facilitate this end, the Parent Program Data and Questionnaire form (Appendix A) was handed out. The form was untimed and remained anonymous. Each parent had little difficulty in filling out the form. This author then asked for any questions. There were none. There were, however, once again thankful sentiments for the group's existence and direct thanks to this writer for its creation.

With the conclusion of all necessary Parent Program business, this writer then presented an overview and definition of extrafamilial sexual abuse. The spectrum of child-abuse behaviors was reviewed and discussed. These behaviors were presented in the three categories of: non-touching, touching, and violent. Talk flowed quickly and easily, with no apparent reticence on the part of the parents to discuss feelings. In fact, there was difficulty in allowing many of the parents to complete thoughts. However, this author must share that intense anger and frustration were the dominant feelings of this first session. These parents also had difficulty separating and they lingered in the office parking lot for over an hour at the

conclusion of the first session.

Session II (September 17, 1986): Myths of Sexual Abuse and Sexualization of Normal Developmental Issues (Appendix F) began with a true-and-false Sexual- Abuse Questionnaire (Appendix G). This questionnaire increased the parents' knowledge about the prevailing myths in the area of child sexual abuse. Each question was reviewed and discussed within the group.

Characteristics from Caplan's (1983) Landmarks in Physical, Psychological, and Social Development were used as a reference point by this author for beginning a group discussion regarding the sexualization of normal developmental issues by parents of sexually-abused children. Normal sexual development was contrasted with abnormal sexual development as might be exhibited by a sexually-abused child. Lastly, the effects of sexual abuse on a child's sexual development was presented.

This author took a few minutes before the end of group and passed out literature from two victim advocacy programs Mother's Against Drunk Driver's (Appendix H) and Sunny Von Bulow: National Victim Advocacy Center (Appendix I). The parents were encouraged to recognize that these were but two of many national and local programs which are available to help or be helped by victimized parents.

Session III (September 24, 1986): The Effects of Sexual Abuse on Child/Parent/Family (Appendix J) was the topic for this

session. The behavioral indicators of sexual abuse on children in the physical, social, and emotional realms were reviewed. The handout, Signs of Child Sexual Abuse (Appendix K), was given to each parent. They were asked to check how many of the behaviors under the appropriate age their child manifested.

A list of general behavioral indicators was reviewed and discussed. This area generated so much discussion that we were only able to complete the discussion concerning family responses. Parent and marital effects had to be kept for next week's session. There was also no time remaining for the informal parent discussion.

Session IV (October 1, 1986): Parental Responses (Appendix L) was the focus of discussion. The effects of the sexual abuse of their child was discussed within the framework of Elizabeth Kubler-Ross's (1976) orientation of the loss process. The five response stages of Anger, Denial, Bargaining, Depression and Acceptance to a loss were reviewed and discussed with the parents. A parallel was then drawn to these parents' responses. These parents viewed the trauma to their child as a "death"--death of the child's innocence; the death of the parents' hopes and wishes. This discussion proved to be one of the highlights of the group.

Inappropriate parental coping methods which were the result of parental feelings enabled the parents to understand the

importance of appropriate responses and reactions in shaping the child-victim's responses. Strategies to help the parents cope with the sexual-abuse stress using appropriate coping methods were discussed.

A handout, Tips to Help Parents Cope (Appendix M), was given out at the conclusion of this session. Parents were encouraged to maintain patience throughout this long and difficult process.

Session V (October 8, 1986): Discipline that Develops Responsibility and Parent-Child Communication (Appendix N). This began with the importance of understanding the goals of the children's behavior. The handouts Goals of Misbehavior (Appendix O) and Goals of Positive Behavior (Appendix P) were used to help facilitate discussion and reinforce the concept.

Differences between a reward-and-punishment system and natural and logical consequences were reviewed next. The basic principles of natural and logical consequences were specified and discussed in detail. Although role-playing typical family problems had been scheduled to allow the parents opportunities to practice the application of natural and logical consequences within the group setting, time ran out. This section was left for the next meeting. Parent-child communication was highlighted from the underlying perspective of enlisting the child's cooperation. Handouts Engaging a Child's Cooperation (Appendix Q) and Quick Reminders for Effective Communication with Children

(Appendix R) were given to the parents at the end of group. To further enhance the principles discussed in Session V, Children: The Challenge, by Rudolph Dreikurs, (1964), was suggested as supplemental reading.

Session VI (October 15, 1986): The Use of Time Out and Behavioral Contracts (Appendix S). Since the previous week's group generated so much interest and discussion, major points in the application of natural and logical consequences were reviewed. Rather than the scheduled role-playing, a long discussion centering around specific parent-child conflicts within each group participant's home took place. This was a lively discussion with much input from all group members.

A handout Time Out for Behavioral Problems (Appendix T) was reviewed as a group. Particular attention was given to the importance of proper implementation within the time-out procedure. Highlighted were suggestions as to why time out might not be working effectively with parents. This also generated much discussion among the group participants. A quick overview of how to implement behavioral charts and behavioral contracts ended this session. Two alternate forms of Behavioral Contracts (Appendices U and V) were given to parents as sample formats that could be used in home contracting with their children.

Session VII (October 22, 1986): Protecting Your Child (Appendix W). This in-depth session, excerpted from Protect Your

Child by Laura M. Huchton (1985), dealt with pragmatic strategies and suggestions for children's protection within the following environments: (1) stranger awareness; (2) safety away from home, i.e., malls, supermarkets, automobiles, schools, churches, synagogues, public restrooms, public swimming pools, parks and playgrounds, movies, doctors/dentists' offices and hospitals, and children's day-care centers; and (3) safety at home, i.e., parent-child distress words, answering the door and telephone, babysitter, and yard/neighborhood safety. The in-depth nature of this presentation coupled with an extreme amount of parental involvement made it impossible to cover all the planned material. Parents were encouraged to purchase Laura Huchton's book as an invaluable resource for their home library.

Session VIII (October 29, 1986): The Final Session (Appendix X). Material from the previous session on Protecting Your Child was discussed and completed. A question-and-answer period was held, allowing parents a final opportunity to clarify any subject material or ask any questions. Interestingly, rather than going back over material on sexual abuse, the parents moved the focus of the discussion forward towards sexuality and adolescence. Issues of self-worth, self-concept, the right to say No, birth control--all were themes discussed. An informal discussion followed where parents shared their feelings about being part of this parent group. At the conclusion of this final session,

parents were presented with a Parent Program Assessment and Evaluation form (Appendix Y) to help evaluate the effectiveness of the Parent Program. Due to the reluctance of the parents to terminate, it was suggested we meet again the following Wednesday evening, but this time it would be for dinner at a nearby restaurant.

A number of minor difficulties arose during implementation. These need to be reviewed by anyone who might attempt to replicate this practicum. Although initially the Parent Program was scheduled for 7 p.m., at the end of the first meeting parents asked if the time could be changed in order to allow them a little more leeway to get home from work, eat dinner, get their children settled, and come to group. For some of these parents who had children in a latency-age girls' sexual-abuse group, it meant two trips back and forth to the office within the span of two hours. This writer had neglected to consider this in scheduling the day of the week for the Parent Program. Because of the commitment of this particular group of parents, this did not become a difficulty for the two families involved. This author feels that, in retrospect, it would have been easier to do the Parent Group program on a night different from their children's group.

Another difficulty which arose at the first session and seemed not to be able to be rectified was the audiotaping.

Although parents were aware that each session was being taped, this author set up the audiotaping at the first session so it would be out of sight of all parent participants. This was done in hope of decreasing any anxiety or inhibitions. However, this proved to be ineffective in picking up the parents' conversation and resulted in no recording, for the first group. At the second session, the outlet that this writer used had a faulty switch. This resulted in only half the session being taped. By the third session, this writer had placed the tape machine on a coffee table in front of the parents in an attempt to maximize recording potential. Although parents did not seem to be uncomfortable with the tape recorder in full view, when the machine signaled that the tape was at an end, inevitably a comment was made. These comments usually were in a humorous vein: "Whoops! Stop talking. We have to wait until the tape is flipped." These remarks were often out of synch with the tone and content of the group discussion. In the last few sessions, the taping produced no comments, no awkwardness, and no change in the flow of the parents' conversation. The group just went on. However, this writer found herself feeling agitated when tapes had to be changed in the midst of group communication. This writer should have checked out the equipment, the setup, and this writer's own skills at working the audio equipment prior to the starting of the Parent Program. Perhaps another professional in the office

should have been asked to help with either suggestions for better audiotaping or might even have been included in group and asked to be responsible for the proper recording.

The two-hour length for each session was appropriate. This writer does not believe, given the intensity of both the subject matter and the subjects, that a longer group session would have been effective. However, problems arose and this writer found it difficult to end each session. The group proved difficult in directing toward a recap or summation process toward the end of each session. As this writer ended, often important conversations continued or began anew. This went on despite the verbal message that "group had ended for the night". Even in the midst of cleaning up and putting away equipment, parents continued to talk. No one was eager to stop talking nor, for that matter, it seemed to leave. This writer found that parents lingered in the office until it was locked, and then often in the parking lot up to an hour after group.

Due to the amount of conversation generated by each topic, this writer was not able on a number of occasions to get through all the prepared material. Subject matter had to be either carried over to the following week or had to be instantaneously revamped and presented in an abridged form. There was too much curriculum information planned for an eight-week Parent Program. If this writer were to replicate this program, the curriculum

would undergo a paring-down for an eight week program. Using the same curriculum, the group length could easily be expanded to twelve weeks.

Since each subject area generated so much discussion, the pre-group decision split format of one hour didactic and one hour informal parental communication was shelved after the second week. Instead, both processes seemed to meld together. All curriculum information seemed to automatically evolve into an informal discussion among the parents. This writer became not only the presenter but also the facilitator.

CHAPTER V

RESULTS, CONCLUSIONS, AND RECOMMENDATIONS

RESULTS

This practicum was designed to provide for parents of the extrafamilial sexually-abused child an understanding that the sexual abuse of a child is recognized as a major trauma with consequences for children and their families, both during the time of victimization and for many years thereafter.

To help gather demographic information regarding these parents, the scope of the sexual-abuse victimization of the child, and their feelings regarding the trauma, parents were surveyed the first session of the eight-week Parent Program, using the Parent Program Data and Questionnaire form (Appendix A).

Attending this first session of the Parent Program were 11 parents: 3 married couples, 5 single parents. With the exception of one couple who brought their neighbor, no one in the group knew each other before the first evening of the Parent Program. Of the single parents, 4 were females and 1 male. Two of the females were married, 2 were separated. The single male was a widower.

Of the four female parents who attended the group without their spouses, reasons given for non-involvement were: Two females who were separated cited unwillingness of their husbands to be involved. (As reported by these parents, this held true not only for this program but also in almost any aspect of their child's life.) Work conflict was noted as the reason for one father's non-attendance. The other father felt it was unnecessary for either him or his wife to be involved in this group. It was reported during this first session by the attending parent (stepmother of the sexually-abused child) that her husband (natural father of the sexually-abused child) was angry at his wife's involvement. He felt the group was "unnecessary and would only make things worse". He not only refused to attend but, on two occasions, purposely attempted to sabotage his wife's attendance.

Ten of the parents were white; one single female parent was black. Ten parents volunteered for group participation; one parent was adjudicated by the State Department of Health and Rehabilitative Services.

The median age of parent-participants was 33.6 years (females: 32.5 years; males: 35.5 years). The total number of children parented by the group members was 26. This included natural, adopted, and step children. Family size ranged from 1 to 5 children. Ages of children ranged from 1 to 14 years.

Seventy-three percent (73%) of the parents worked full time; 27% were primarily homemakers.

In terms of education, 100% of all parents had completed high school, 27% had completed an associate of arts degree, and 18% had received a bachelor's degree.

With respect to socioeconomic status of the parents in attendance, 73% had incomes over $25,000, 27% had incomes below. Occupations were predominantly service-oriented. Within the group were two firefighter-paramedics, two nurses (one registered, one practical), and one couple who owned and operated a preschool nursery.

The number of sexually-abused children was 10, with one parent having experienced multiple sibling sexual abuse. (In this instance, the adoptive father had custody of his adopted child. This child had been sexually abused by her natural mother and she then, in turn, became the abuser and abused two of the adoptive father's second wife's natural children.)

Parental relationships in the group to the sexually-abused children were: 4 adoptive parents, 2 steparents, and 4 biological parents.

With one exception, all of the victims were female. The sex of the perpetrators was mostly male. One female child was implicated as an abuser. This corresponds with Finkelhor's (1984) random Boston study where 94% of the reports perpetrators

were male and, in self-reported sexual abuse experienced by parents, 97% were male perpetrators. This seems to add additional evidence against the idea that there is a large volume of abuse by females. The mean age at onset of the sexual abuse was 5.9 years. The mean current age of the child-abuse victim was 9.4 years.

Disclosure of sexual abuse was primarily from the victim or the victim's sibling directly to the parents. Parents seemed to be the adults to whom children most frequently reported the sexual abuse. In every case, when these parents became aware of the sexual abuse of their child, they first notified the police and than HRS. There were no sexual-abuse cases unreported in this Parent Program. Time of the disclosure to the parents, from the onset of the first sexual-abuse act itself, ranged from a few minutes to five years. Table I reflects the parents' rating of the degree of violence used in the sexual abuse of their child. Physical and verbal threats were the two types most reported by parents. The 45% verbal threats reported by these parents correlates with Finkelhor's (1984) Boston random study, in which parents reported 54% of experiences did not involve physical contact.

Table I

Parents' Ratings of Degree of Violence Used in Sexual Abuse

TYPE	% PARENTS* (N = 11)
None	27
Verbal Threats	45
Physical Force	45
Genital Tearing	18

*Does not sum to 100. Respondents chose more than one category in many instances.

As shown in Table II, the types of sexual contact most reported by the parents as used in the sexual abuse of their child were fondling, exhibitionism, and oral. Rape and pornography were the least reported.

Table II

Parents Ratings of Degree of Sexual Contact Used in Sexual Abuse

TYPE	% PARENTS* (N = 11)
Pornography	18
Exhibitionism	45
Rape	18
Fondling	90
Oral	36

*Does not sum to 100. Respondents chose more than one category in many instances.

Within the two categories in Tables I and II, it was noted by this writer that married couples marked different responses from each other when reporting on the same child in the above referenced categories.

Parents reported the abuser most often as either a trusted neighbor or a friend. There were two cases where the abuser was a stranger to both parents and child. One married couple both reported the abuser of their child as a stranger. In actuality, this abuser was--and remains--a neighbor who lives down the block. It is this writer's assumption that, on the questionnaire, when the word "neighbor" was prefaced by "trusted", these parents were unable to reconcile the abuser with the concept that, before the abuse, he was, indeed, a "trusted neighbor". Therefore, they referred to him on the questionnaire as a "stranger".

Seventy-three percent (73%) of the parents reported that they did not talk to their child prior to their becoming a sexual-abuse victim, although 100% of these parents responding knew what child sexual abuse was prior to the victimization within their own families.

Fifty-five percent (55%) of parents responded that they felt they understood how sexual abuse affected children. One hundred percent (100%) of these parents said that sexual abuse affects kids "a lot". This is a different result from Finkelhor's (1984)

conclusion that the parents in his Boston study in general did not think their children were going to suffer ill effects because of the sexual abuse.

Eighty-two percent (82%) of these parents reported feeling overwhelmed by the sexual abuse of their child. Most felt that it increased stress in all areas of their lives. As Table III shows, the environments most reported as affected by the sexual-abuse trauma were self, family life, and the parents' relationship with the abused child.

Table III

Parents' Ratings of Increased Stress
Due to the Sexual Abuse of Their Child

ENVIRONMENT	% PARENTS (N = 11)
Self	100
Family Life	100
Work	64
Relationship with Significant Other	73
Relationship with Abused Child	100
Relationship with Other Children in Family	50

Sixty-four percent (64%) of the parents felt alone as the parent of a sexually-abused child. Of the 36% who did not feel alone, all were married parents. Seventy-three percent (73%) of the parents felt they did not have an opportunity to express

their feelings about the sexual abuse. Of the 27% who felt they were able to express their feelings, all were the three married males in the Parent Program. It seems that being a married parent of a child sexual- abuse victim at least affords one the opportunity of feeling less alone and unsupported.

Eighty-two percent (82%) of the parents felt that they had no adequate personal-support system. Those 18% who felt lucky enough to have people to share with cited family and friends as those supports. One hundred percent (100%) of the parents reported feeling that there were no adequate community support systems for their problem. Although only one set of parents reported attempts to find programs within the mental-health community, these parents' perceptions were correct. Except for the one mixed parent support group, there were no community programs available for these parents. Eighty-two percent (82%) said that if they had known such a system was available, they would have used it.

The two most prevalent types of feelings reported by parents at the time of the sexual abuse were those associated with denial, (Examples: "Disbelief", "Shock", "Cool numbness") and anger (Examples: "Rage", "Mad", "Wanted to kill", and Angry"). Two fathers responded that their feelings at the time of the abuse were that they "felt inadequate as parents". These feelings are similar to both Russell (1983) and Finkelhor's

(1984) findings regarding parental responses in both real and hypothetical cases to the sexual abuse of their child.

Many of the parents described their current feelings about the sexual abuse with the exact same words used to describe their emotions at the time of the abuse. Anger and denial were most prevalent. But this time there was an additional underlying theme of helplessness and sadness. This was evidenced by phrases such as "a sense of loss", "feeling that even justice will not change things". One parent poignantly wrote, "I'd like to move on the way it used to be, but I know we cannot. So I don't know how to feel". Although 91% of the parents felt when the sexual abuse was disclosed they managed the situation as necessary, 64% of the parents felt that there was something that they, as parents, could have done to prevent the sexual abuse. Positive parental feelings about the manner in which they themselves have handled the stress of sexual abuse since disclosure is evidenced in Table IV.

Table IV

Parents' Ratings of Positive Feelings About
the Manner in Which They Handled the Trauma of Sexual Abuse
Since Disclosure

RELATIONSHIP	% PARENTS (N = 11)
Self	64
Abused Child	64
Other Sibling	45
Significant Other	27

However, these same parents reported not feeling good about the way they had handled the ongoing stress of sexual abuse. Primarily, they reported, this was evidenced in the relationship with their spouse.

Parental concerns about the problems that their children will have as a result of the sexual abuse are noted in Table V. The effects that most worry the parents were emotional, sexual, social, and school-related problems.

Table V

Parents' Concerns About Effects of Sexual Abuse

EFFECTS	% PARENTS* (N = 11)
Emotional	91
School	45
Social	73
Sexual	91

*Does not sum to 100. Respondents chose more than one category in many instances.

The most serious problems that these parents of sexually-abused children cited as their own worries about their child's sexual abuse could be loosely defined in two categories: parenting issues and ongoing fears and worries. Examples of parenting issues are the following type of response phrases: "Regaining my sense of worth as _____'s parent", "Not knowing if she is behaving normally or that way because of the abuse", "I worry about being an over-protective and over-reactive parent". Some of the ongoing fears manifested by these parents are seen in the following phrases: "Since she has become sexually aware at a young age, will she become promiscuous when she's older?", "Will we be able to cope with our own guilt?", and "I am continuously worried that she will not be normal emotionally and sexually". Finkelhor's (1984) Boston study of Boston Parents showed the same general categorical concerns.

The data from this questionnaire clearly indicated a group of parents who were feeling isolated, alone, abandoned, stressed, unsure of themselves as individuals and parents, angry at the victimization of their child and families, and lacking opportunities in which to both discuss and receive direction with their feelings regarding the sexual abuse of their child. Both the quantity and intensity of their problems could only be affecting themselves and their family and be exacerbating an already-traumatized and victmized child, parent, and family.

A program of eight weekly group sessions was chosen as the method to increase these parents' knowledge of sexual abuse and its effects on both the child victim and on family members, to enhance parenting-management skills, to help facilitate an opportunity for parents to express their feelings about the sexual abuse of their child, to decrease through this Parent Group the sense of isolation, and to reduce stress by learning new adaptive behaviors and resource strategies for coping.

Results of this Parent Program were evaluated by a number of different measures and techniques, such as questionnaires, audio tapes, and anecdotal responses by parent participants.

Initially, this writer was concerned with the attitudes and willingness of this population to even enter into a group-type situation. Many of these fears were dispelled by the parents' responses to this writer's initial telephone solicitations. However, concerns still manifested themselves. Would those who had committed verbally on the phone really show up at the first meeting? Would parents then become consistent in their group attendance?

At the first session, 11 of the initially-committed 15 parents were present. Attendance figures over the eight weeks ranged from 11 to 6, with average parental attendance being 8. Four parents attended all 8 sessions--these were the two married couples--an indicator that marital support may be an important

reinforcement that affects parental commitment to this type program. Two parents missed one session and two parents missed two sessions. One couple dropped out after a perfect attendance the first four sessions because of a personal problem. The eleventh group member attended only the first two sessions and then never returned. This was the parent who was adjudicated to attend this group through HRS. After trying unsuccessfully for two weeks to make phone contact with this parent, this writer was contacted by HRS regarding their client's group attendance. Although only one parent was involved, adjudication, as compared to self-referral, could also be an important factor in group attendance.

Reasons for absences from group usually were reported to be the result of either work-schedule conflicts or babysitter problems. In one instance, one absence was due to the deliberate sabotage of group attendance by one parent's husband. Overall, there was an intense need and desire by these parents to attend the Parent Program. One father told the group "She (his daughter) asked me today, 'Are you going to group tonight?' I said, 'You Betcha!' because she knows how upset I've been the two nights I've missed when I've been at work. She reads that out. I don't have to say a word. She knows how much this means to me!"

Another concern was that the same anxieties and fears that

might have prevented the parents from attending group initially might still make them be unable to trust and therefore open up to each other. The ability of these parents to become cohesive through the sharing process proved to be an unnecessary concern.

The first group session found these parents literally coming through the door and beginning to share with one another even prior to personal introductions. Over and over again through the eight weeks, this feeling of closeness, of kinship between parents was talked about directly and shown in many, many ways. Certainly the amount and degree of self-revelation within the group was a measure of the group's ability to trust. Often parents addressed issues which were prefaced by phrases such as "I've never told this to anyone, but _____ (husband/wife) before", "I've always been ashamed to say this, and I've never even told _____ (husband/wife) this, but...", "I don't even feel guilty saying this to you all. Your're t: only ones who I can say this to and who I know will understand".

The instant rapport that this writer sensed was there from the first session was also noted by many of the attending parents. One father commented to the group: "You know, I don't like going to meetings and meeting a bunch of strangers and stuff. But I walked in here the first night, I don't know, it was...I don't know what it was, but I felt comfortable from that very first night". Another husband--whose wife commented over

and over through the eight weeks that she had never seen her husband talk so much about anything, let alone their sexually-abused daughter--made the statement, "It is not only confiding what has happened to people that I don't know. That just came natural. I don't know what other to say: it just came natural. I never had any problem feeling a closeness with any of you".

At the eighth and last group meeting, each parent present was evaluated, using the Parent Program Assessment and Evaluation form (Appendix Y). This questionnaire was an objective measure of obtaining those specific practicum objectives as previously listed in Chapter III and addressed below. Seven parents were present at the last group meeting. The following data reflect these parents' responses.

Meeting the general goals of increased knowledge of sexual abuse and the application of that knowledge within their families, parents were assessed under the following specific objectives:

Objective 1: Parents will indicate an increase in their knowledge of: (a) myths about child sexual abuse, (b) the spectrum of sexually-abusive behaviors, (c) behavioral indicators of child sexual abuse, and (d) effects (physical, emotional, and social) of sexual abuse on the child/parent/family. As shown in Table VI, 100% of all parents indicated an increase in knowledge by their answers to Questions 6, 7, 8, and 9 on the Parent

Program Assessment and Evaluation form.

Table VI

Objective #1: Meeting the Goals of Increased Knowledge of Sexual Abuse

Specific Objectives	Parent Program Assessment & Evaluation Form	% of Affirmative Parent Responses (N=7)
a. Myths about sexual abuse	Question 6: Do you feel that you have now increased your knowledge about the myths of child sexual abuse?	100
b. The spectrum of sexually-abusive behaviors	Question 7: Do you feel that you have now increased your knowledge of child sexual abuse?	100
c. Behavioral indicators of child sexual abuse	Question 8: Do you feel that you now know the behavioral indicators of child sexual abuse?	100
d. Effects (social, psychological, & emotional) of sexual abuse	Question 9: Do you feel you now understand the effects (social, psychological, and emotional) of sexual abuse on the child/parent/family?	100

Objective 2: To understand how parental reactions to the sexual abuse of their child can affect both themselves and their families.

This objective was measured on the Parent Program Assessment and Evaluation form (Appendix Y) by three questions which indicated an increase in awareness of their behavior by the

parents.

Question 16: Have these sessions helped you as a spouse? Yes/No. In what way?

Eighty-three percent (83%) (5 out of 7) felt the sessions to be extremely helpful in their marital relationships. The issue most specifically addressed was that of communication, as reflected by the following comment from one wife: "_____ has always been so quiet. He has really taken part in group and this has helped our communication at home." Her husband responded to the question in this way: "Yes, it helped me in being able to talk to my wife. It helped my wife to talk and understand me." But this increased communication was noted by several parents to directly affect how they themselves were feeling. The following comment exemplified this concept: "I feel I can express my feelings now on a regular basis with my husband. I am not as depressed or as angry anymore or as helpless as a person nor a parent."

Also noted by some of the parents was the ability now to understand, accept, and tolerate their spouse and the way in which they have responded to the trauma of sexual abuse. One parent wrote: "I am now able to accept where my spouse is and allow her to deal with it in her own time and way. I don't tell her anymore that she's wrong in her feelings."

The one negative response came from the parent whose husband

had attempted to sabotage her group attendance by not coming home in time to babysit as promised. This mother shared that, after talking to some of the group parents, she had changed her opinion about all wing the perpetrator of her stepdaughter to plea-bargain. She said: "From that point on, _____ says, 'You're just going by what your group says. It's your group this and your group that.' And he resents me, I think, coming here. I think he resents that I've gotten more from coming here than he's been able to give me. But, you see, _____ has to work so much, he can't make time for stuff like this (facetious tone of voice). You remember last week when I came an hour late? Because he thought I wasn't going to come at all. It's not an issue with us--I'm not mad at him so much about it anymore--but I'm not going to let him ruin this for me. He thought, by coming in at 8:15, I would miss the whole session like I did the second meeting. He came in and I said, 'Oh, good I'll have at least an hour to go'. And I came!" Although this parent checked NO in response to Question 16 and the wrote: "My husband...Never mind", this writer believes that the previous anecdotal response clearly indicates by the phrase "I'm not mad at him so much about it anymore" that she also had gained the ability to allow her husband to handle the sexual-abuse of his child as he needed. But she also asserted her right to deal with the situation as was best for her.

Question 17: Have you noticed any behavioral changes in your sexually-abused child because of your participation in the Parent Program? Yes/No. What type of changes?

One hundred percent (100%) of the parents acknowledged behavioral changes in the victimized child, which they attributed as a direct result of their participation in the Parent Program.

Again, communication was the area most noted by parents in which changes occurred. The following comments by the parents are reflective of those changes: "My child is more willing to discuss problems", "She is more comfortable with me now and discussion flows freer". Parents also noted changes in their child's behavior in regard to school-related issues: "She's more responsible in her school work", "She is excelling in class now. She doesn't get slowed down in school by her need to be perfect in what she's doing. She seems not to be as irritable and is more relaxed in everything she does".

Two parents responded affirmatively to this question but commented on their own behavioral changes rather than their child's. One mother poignantly wrote, "I thought it was all _____'s fault. Now I realize I was blaming her and a lot of what was happening was my responsibility, too. The changes really are unbelievable." One father commented, "Actually, I've changed in the way I'm dealing with her and my thoughts and attitudes towards her. Because of my changes, she has shown

many, many changes."

Question 18: Have you benefited by your participation in this Parent Program? What has benefited you the most?

One hundred per cent (100%) of the parents affirmed that they had personally benefited by program participation. These free response statements were extremely powerful affirmations of the parents' knowledge of themselves pre- and post-group and the gains they felt were made by group participation. One parent wrote that he benefited most by being able, "To finally understand my own feelings about my child's sexual abuse and to understand how to get through those feelings". Another parent wrote, "I've even been able to confront the offender of my daughter."

When discussing at the last group session the parents' feelings about participation in the program, the parents seemed to continuously use these criteria--attitudinal and behavioral changes within themselves--as the measure of the importance and success of the group. The following excerpt, taken from the final tape, exemplifies this objective: "To hear you all talk about the anger, I was so hung up in the denial it was like, instead of being loaded down with the anger, I was just kind of going nowhere. Plus all the financial problems and losing the business put additional pressure on me. So many horrible things happened simultaneously. This (group) has been the impetus to

make me feel a lot better about myself and my business. I also feel like I'm graduating, like I'm going on forward with my life. Part of it was going through the anger thing and dealing with it and coming to grips with what to do and what not to do. One day I realized, about three weeks into group, that I was angry and so I took off for about four days to see every lawyer I could. I still don't know what I'm going to do, but it was worth the energy, because I did go through the anger and, in the group process, I picked up a burden, that burden of anger. But I'd much rather have picked up that burden of anger and carry it than sit where I was, just sitting in denial. Of course, as the weeks went on, I unloaded the anger in group. That's been just wonderful for me and I feel like I'm going on with my future."

Objective 3: To have an opportunity for parents to express their feelings about the sexual abuse of their child.

One hundred percent (100%) of the parents responded that they felt that they had an opportunity to express their feelings about the sexual abuse of their child. Over and over again throughout the eight-week program, the ability to honestly talk about their feelings in regard to the abuse was a theme echoed by all the parents. One mother described how, when she drives car pool, she doesn't even hear the kids in the car because, in her mind, she is fantasizing about mutilating the perpetrator. As she described these fantasies, she suddenly broke down, weeping, and

asked for reassurance from the group that she wasn't "sick or crazy". Others were able to negate her fears by sharing their own similar thoughts. One parent described how she had often made decisions not to discuss the sexual abuse and has "put on this act, but I never had to do that in this group. I feel comfortable telling anything. You could ask me anything about the abuser, I'll tell you. I could tell you anything." Another parent chimed in with "What else can you say to people? We know about this; no one else will understand but us!"

Often parents lamented that there was no one to talk with about the abuse. Although they all realized that it was an uncomfortable subject, there were still feelings expressed of extreme disappointment, anger, and hurt. These feelings were intense when it came to their own natural parents who were felt to be either non-supportive or non-involved. One parent disclosed that within her family neither her parents, nor her brothers and sisters, had every discussed the sexual-abuse issue after its initial disclosure: "All this time, all this pain, and they have never even asked!"

Another parent felt that her sexually-abused daughter had become the "bad one" in her parents' minds. Previous to the abuse, this daughter had clearly been her grandparents' favorite. Since the abuse, this daughter could do no right and now her sister could do no wrong. It had reached such serious

proportions that this granddaughter now refused to visit her grandparents' home. Differences in how family members felt the parents should be handling the trauma also caused much conflict and stress. In particular, there was the theme that these parents were "making too big a deal out of this whole thing". "Really, _____, don't you think it's about time you stopped crying and just forgot all about it?" The absence of family support was very, very painful to these parents and only served to further enhance their feelings of abandonment and isolation.

Friends, neighbors, co-workers were felt "to not really understand" or "not really care", even though these parents often chose these people with whom to discuss their feelings about the sexual abuse. "Did you ever notice how, when you mention it, they look at you kind of funny? And you don't even realize that they don't understand until you walk away, kind of empty." However, this parent confided to the other parents that now that he was in the Parent Program, he talked about group at work: "They look at me kind of funny, but I tell them, 'Hey! I need all the help I can get, baby! It's as simple as that. You ought to all come on down!'"

One father broke down and wept when he told the group how the ability to communicate in group had helped him: "You know, one night _____ pointed out to me that I had so much anger. Well, I feel a hundred pounds lighter. There was so much anger

that I was carrying around, so much anger that I didn't realize. And it's gone. I just feel tremendous!"

However, dealing with the sexual abuse and expressing their feelings took its toll on these parents. Many were able to acknowledge this reality as the following discussion shows during one group meeting: "A couple of nights we've been down here, on the way home I've commented to _____, 'My God! I'm just exhausted!'" Another parent added: "Oh, yeah. It's been a gosh-darned thing. They ask me how was your group at work, and I'd say, 'Man! I'm wiped. It's a drain. Man, I'm wiped! It's intense.'" One mother reflected: "Thursdays (the day following group) is always a rough day for me but by Friday I feel much, much better."

Objective 4: To build parental self-esteem by learning new strategies relative to child-behavior management and child safety. The results of this objective were assessed on the Parent Program Assessment and Evalution form (Appendix Y) by the following two questions: (10) Have you learned new methods of parenting your children? YES NO and (14) Have these sessions helped you as a parent? YES NO. In what ways? One hundred percent (100%) of these parents responded in the affirmative to both questions. Yet this objective dealing with specific parenting skills--not parenting skills related to a sexually-abused child--had an importance for these parents beyond the

writer's anticipated expectations. This was seen within the process of the group in many ways and on many different levels.

Session V that dealt with natural and logical consequences as well as Session VI in which time-out and behavioral contracts were discussed became a turning point in the eight-week Parent Program group process. When one listens to the audiotapes of the Parent Program, one cannot help but be struck by the intensity of the anger and rage of these parents as they dealt with the many aspects of child sexual abuse throughout the first four weeks of the group. However, Session V produced a whole different mood. This was carried over to the following week when parenting skills were once again the focus.

From the moment this author began to discuss the issue of "parenting", parents responded in an affirmative, almost-jovial manner. These hours became filled with laughter, as all parents shared their successes, their failures, and their frustrations and vulnerabilities as parents. This topic seemed to change the focus of these parents to "their kids" as opposed to "their sexually-abused kids". It seemed as if the common thread with these parents was not so much their victimized child but their parenthood. For this writer, this was a healthier connecting bond.

In the last session when the parents talked about the meaning of group and their wish to continue, "parenting" was the

direction in which the group wanted to move. One parent gave testimony to the differences this could bring about: "Couldn't we go a few more weeks and discuss parenting stuff? I have so much to learn! After you started telling us here about trying different things, I tried it at home. Everything is so much better now! It's so good at home! She's really beginning to become my child. I think it's me. I've changed. I used to think it was all her fault. Now I see my responsibility and what I was doing wrong." Other parents immediately chimed in: "Gosh, I need parenting skills. I really do!" "Boy, do I agree! I need help there, too."

The child-behavior-management discussions which focused on the normal parenting concerns seemed to generalize and allow the parents to begin looking at their children differently. As one parent commented, "I have been helped in here by not feeling any more that _____ is abnormal because of all this and that. I overreact. I go overboard on what she does because I think, 'Oh, God! That's because of this or that or Mr. _____ (perpetrator).'"

Parenting concerns were again raised when the group began to reflect on the coming years with their children. As the focus shifted towards the issues that adolescence would bring, parents began to echo a common lament: "How should I as a parent help my child to have the right values?" These normative parental

concerns regarding the instillment in children of the importanct of certain values also bonded the group. They were amazed to realize that everyone in that room shared the same fears, the same hopes, the same desires. The parents confronted this writer with the possibility of have a parent group where we could discuss these concerns and issues.

Objective 5: To reduce parental stress by learning new adaptive behaviors and resource strategies for coping with stress. One hundred percent (100%) of the parents answered YES to Question 14: Has this group helped reduce your stress as the parent of a sexually-abused child?

Stress reduction for these victimized parents had been, in this writer's opinion, an inherent byproduct of group particiption as each of the practicum objectives were achieved. Statements reflecting this are of this type: "I can't believe how much better I feel. I feel so much lighter. I'm amazed at the energy I've got now. I finally started to wallpaper my kitchen, which I haven't felt like doing for two years." Most vividly, however, this writer believes stress reduction can be traced in the tracking of the group process from the first meeting through the last one eight weeks later. This writer was totally unprepared for the intensity, the anger, and rage that was evident at Session I. The first session was nothing but a series of cross-conversations. No one allowed anyone else to

talk. Tonal quality was harsh, abrasive, and brittle. One parent began to speak, others interjected. It seemed as if no one allowed anyone else to finish. The need to ventilate and be heard was staggering. Rules of etiquette pertaining to communication with another person were left by the wayside. This writer was shocked by this occurrence because my concerns had been the reverse: how to get these parents to begin opening up.

In self-assessing the facilitating of the first session, this writer felt that the group was out of control and group management on my part was poorly done. Concerns turned toward the need to tighten up structure and perhaps present group rules that must be followed so parents could both talk individually and be allowed to finish. This chaotic first session was the direct result of the stress levels that these parents had on entering group. Although the ventilation need remained constant and created some problems in group structure and process, each week saw a decline in these factors. Parents began to allow others to speak without interruption. As some of the parents began to relax, they truly began listening to the other parents, and the communication patterns changed to reflect this. Support, empathy, and suggestions were offered. Parents began responding to other parents rather than communicating from a parallel position of pain and anger. Tonal quality softened. As anger abated, other feelings surfaced. Many tears, frustrations, as

well as laughter and joy, surfaced within the group. The last group session saw parents who wept with each other but they wept from a sense of having overcome a terrible burden. These parents felt as if they had gone through a dark tunnel and were finally seeing light, hope, and joy. There was no trace of anger in the tape of the last group session.

One might also look at the lessening of stress over the eight-week period as a direct result of these parents having an opportunity to mourn their loss. It became apparent to this writer, after reviewing Sessions I and II, that these parents felt as if the sexual abuse of their child had caused them, on psychological and emotional levels, to lose their child. This writer became aware of this when one parent said he felt "that there was nothing short of her death that could have been worse than the sexual abuse". He then, with tears rolling down his cheeks, admitted that "perhaps even with her death there would have been a finality" that he felt was never going to come with the issue of sexual abuse. Because of this realization, this writer introduced a topic that had previously been unplanned. This was Elizabeth Kubler-Ross's (1969) five stages of loss: denial, anger, bargaining, depression, and acceptance. These stages were used as a structure for the parents to understand the process they were going through. They were quick to understand and agree. Parents began, even while this writer was speaking,

to pick up the theme. One parent interrupted me and said, "No wonder! That's why he wouldn't talk to me about it. He was denying it. He was still in the denial stage, and I was in the depression stage. No wonder it was so difficult for us!" One could almost see the "aha" response from these parents.

Once the parents began to understand the grieving process, they began to become less angry and to have more understanding of each other's responses. Certainly the type of feedback on the questionnaire, where one parent wrote "I can allow her to handle the sexual abuse in her way and I can be allowed to handle it in my way", was evidence of the understanding of this type process.

Using Kubler-Ross's (1969) stages of loss and looking at the eight-week Parent Program, one can perhaps track the sessions themselves through the same five stages of denial, anger, depression, bargaining, and acceptance. Certainly, acceptance of the sexual abuse was finally indicated when, at the final session, parents used phrases as "graduate" and "get on with my life". The Parent Program lessened stress because it allowed these parents to go through the process of grieving and did so in a directed, structured, time-limited, and supported way.

Acceptance of the trauma, and with it, the lessening of stress, was also indicated to this author in another way. Session VIII, the last session, was left without a specific planned agenda. This writer had decided to do this so that, if

there were any issues that needed to be addressed, areas of clarification, or additional topics that the parents wanted to discuss, we would have the time available to do so. The last session began with a catch-up to complete the curriculum from the previous week. Following this, this writer told the group that much of the remainder of the session was available to deal with any issue of their choice. One of the parents spontaneously began to talk about her fears regarding her daughter's entry into high school. More specifically, she talked about the value decisions she felt her daughter would be forced to make. Parents began a sincere dialogue about the ethics and values they hoped their children would carry with them into their teen years. Concerns centered mainly around the concepts of self-respect and self-worth. Could they as parents insure that their children would feel good enough about themselves to avoid the mistakes many of them had made? This discussion continued until this writer was forced, because of time constraints, to bring it to an end. There was no mention in this almost-45-minute exchange about sexual abuse. No parent voiced that their concern eminated from a place of fear because they had a particularly vulnerable child due to the abuse. This discussion could have been any group of parents. The ability of these parents to look forward developmentally was one of great significance to this writer. It was interpreted as a symbol that the stress from the sexual abuse

was finally beginning to dissipate. This allowed the parents to move away from the trauma and gave them the energy necessary with which to begin thinking in a positive and forward direction about their children.

At the second session of the Parent Program, this writer began to suggest to these parents the possibility of channeling the energy from their anger and negativity in a positive direction. Pamphlets from local and national advocacy groups were handed out and parents were encouraged to become involved. It was pointed out by the author that these parents had become reluctant "experts" in the area of child sexual abuse. They had knowledge that could help others, and, in doing so, they would ultimately help themselves. There was not one response to this idea when it was suggeted during week two of the Parent Program. However, at the last meeting, the parents began to address this issue. The following are comments excerpted from this discussion:

"I would like to see us pick up a sense of...mission...to do something, at whatever level is appropriate. Maybe just letters. I don't know at what level it would be okay for us, but it would be fun."

"We could begin our own advocacy group."

"But I don't know how to go about doing that."

"We could figure that out."

"Sure you do. Sure you do. All the feelings and problems that we brought our here, we could do it!"

"Don't worry. Together we can. This has been great for us. Before this (group) happened, where were you at? How did you feel? You know how many people are out there feeling the same way we felt before we had this? It's a shame. And they don't know where to go. I didn't know where to go. If _____ hadn't come up with this, I'd still be out there spinning my wheels, beating my head against a tree. We must do something!"

"It's sort of like AA, you know. I would have liked a place to go, like I did here, and hear everyone's story and say, 'If they did it, I can do it!'"

At this group's last informal get-together, these parents set up a schedule of meetings which were to be every other week, in rotation, from home to home. They decided to meet as continued support for each other, as well as plan some type of advocacy action. Also these parents decided among themselves to give their names to this writer's office for use as peer supports to other parents of extrafamilial sexually-abused children who might be going through the same trauma and who might be helped by talking to parents who themselves had gone through a similar experience. Certainly the ability to become an advocate, to move forward, and to give to others requires an energy that stressed, depressed parents would not be able to marshal.

Objective 6: Have an opportunity to decrease the sense of being alone as a parent of a child who has been sexually abused.

This objective was addressed by Question 10: Have you had an opportunity to express your feelings about your child's sexual abuse? YES NO, and Question 13: Has this group helped decrease the sense of being alone as the parent of a child who has been sexually abused? YES NO.

One hundred percent (100%) of all parents answered affirmatively to both these questions. It would be impossible for this writer to record the number of times that this feeling was echoed directly by the parents. It was seen most vividly in the first group session with parents coming through the door and bonding immediately. It was as if that simple need "not to feel so alone" had been already met. From there, it seemed as if this component just grew and grew. This writer believes that, regardless of what was discussed, the competency of presentation or, for that matter, any other issue basic to everything, was the need for these parents not to feel so alone. It was the process of being together as a group--not the group content--that was important. Here are excerpts from the last session in which the parents discussed this concept:

"Listen to _____ (her husband) talk! He has outtalked me on several occasions in this room. I've even tried to butt in and he wouldn't let me. He's never outtalked me. He has never

been that way--ever! In three years, I've never heard him talk that much about anything--anything! And definitely not about _____ (child). I was talking to my sister-in-law and telling her how much _____ talks in group. Tears came to my eyes because it means a lot to me when he says things in group. He needed to be with all of you."

"I needed something to compare myself to. I needed to know I wasn't the only one. I mean, I know I wasn't the only one. People kept telling me that. But I felt no one feels like I felt. I have been helped in here by just listening to you all. It helps me to understand that it's just kid stuff--some of it is just kid stuff."

The following is an exchange among some of the parents: "There is such a bond. We seem so natural for each other. The stigma that you're alone has been brought up before. And it is. There is such an alienation..."

"It is such a totally consuming feeling. I mean, it was for me. I mean, I just felt A-L-O-N-E and I was alone. But I feel so much better now about being able to share things. And I feel good that you all have shared with me."

The importance of being together as a group was evidenced by the group's unwillingness to end each and every session as well as their inability to physically separate from each other. They lingered in the building and then in the office parking lot up to

an hour after group on many occasions. These "informal" group meetings in the parking lot saw these parents laughing, crying, hugging each other, and exchanging slips of paper with pragmatic information about lawyers, prosecuting attorneys, and judges who were sensitive to child sexual abuse, and on and on and on.

One hundred percent (100%) of the parents asked for the group to continue or at least be expanded past the eight-week initial sessions. The range that was asked for was from "10 weeks" to "forever". By the second session, this writer was tracking comments regarding concerns by the parents about the ending of group. "This is group two. We've only got six more meetings." Most of these early comments were said as offhand remarks and sometimes in an almost-humorous manner. However, these remarks accelerated throughout the last four sessions and were most clearly addressed in the last group session both on the Parent Program Assessment and Evaluation form (Appendix Y) as well as verbally. In response to Question 5--What changes would you recommend in the physical facilities, arrangements, schedules, length of program, time of year, etc.?--except for one other suggestion, 100% of the parents addressed the issue of program length and their wish to have it extended. The following are examples of parental comments: "Length of program: Possibly extend to 12 weeks." "I wish this could go on once a week, at least three hours, every day of the rest of my life--because

that's how long I'll be a parent."

When the parents were responding about their feelings regarding program participation, the issue of "aloneness" was commented on by several parents. One parent said, "I think I was pretty seriously depressed before I came to this group. _____ (her husband) knew it. We didn't talk about it, but he knew it. This group has changed my course. I needed not to be alone. I have unloaded a lot of my feelings here and I know I'm going to cry when I say this, because it's going to be hard for me to have this group end, because I really have a lot left...I think." Another parent reflected that Wednesday evenings had become a special night for her; "I'm going to miss it. I really am, because it has meant so much to me coming here. I don't even know anyone's last name. I don't even really know you. But I know you all in a way that no one else will ever know you. Each and every one of you. _____ (her husband) and I like you all so very much. We talk about you, we think about you, and we miss you when you're not here. And I'm going to miss it. I don't know what I'm going to do. I really don't."

After an unsuccessful attempt by the group to get this writer to continue the program, we decided to meet informally the following week for dinner. This evening proved to be one of absolute joy and delight! We all shared food, drink, song, and much, much laughter. Once again, however, this group showed no

willingness to end, and it was only when this author said that she had to go home that the parents became solemn with the realization that the evening was over and the program was indeed completed.

The criteria for measurement of a successful and effective Parent Program were also determined through the Parent Program Assessment and Evaluation form (Appendix Y). Using Questions 1, 2, 3, 4, and 5, the results of Table 7 indicate a successful Parent Program, for 100% of the parents responded affirmatively to all of these items. This affirmation is reflective of a success well above this writer's expectations for the Parent Program and certainly indicates an overall enthusiasm for this program. Consideration of the issues addressed in Questions 53 & 5 might give some insight into additional concerns.

Table 7

Parent Responses on Evaluation of Parent Program

Parent Program Assessment & Evaluation Form	% of Affirmative Parent Responses (N=7)
Question 1: How would you rate the program? Excellent___ Good___ Fair___ Poor___	100 excellent
Question 2: Was the material covered relevant to you? Yes___ No___	100
Question 3: What new topics should be added to future programs? 1. "More parenting skills." 2. "There's probably not time to add more. However, a reading would be good." 3. "More discussion on the subject of how to prepare a child."	
Question 4: Please indicate how well you feel the objectives of the program were satisfied. Excellent___ Good___ Fair___ Poor___	100 excellent
Question 5: What changes would you recommend in the physical facilities, arrangements, schedules, length of program, time of year, etc.? 100% responded "Increase the length of the program". "Children should be involved towards the end of the program."	
Question 19: Would you be interested in attending future Parent Programs? Yes___ No___	100

The reported results clearly indicate that the parents of these extrafamilial sexually-abused children can and will respond to appropriate program offerings. It is evident that, when that occurs, there are positive changes in both the parent and child. The results clearly indicate that treatment must be provided and must recognize with equality the need of the victimized parent as well as that of the child.

CONCLUSIONS

Although the number is certainly small (N=7), based on a comparison of the data pre- and post-Parent Program, there is overwhelming evidence that the victimized parents of the extrafamilial sexually-abused child are in desperate need of intervention strategies. Given knowledge of the opportunities and availabilities to participate in programs especially designed for their population, these parents will attend and be committed to the process.

This author, who was so concerned at the beginning of this practicum whether these parents would even attend, share, or be committed for eight weeks, misjudged the needs of these parents. This writer felt that, since the parents had knowledge of the sexual abuse for a considerable length of time, they were no longer in crisis. However, these parents were still in crisis. It is this writer's belief that the crisis state continued because there had been no interventions, no treatment strategies,

and no support for the parents.

For this writer, there were many outcomes and conclusions that had not been anticipated before program implementation.

1. The intense need of the victimized parents for this group was not expected. It was this need that created the immediate bonding of all participants. This feeling of support, of being together, created results which were much more effective, in this writer's opinion, than any treatment that they might have received individually. It was the support of the group that gave these parents the additional strength needed to finally begin moving forward.

2. Feelings within this group were very intense. It did not matter if the feeling was anger, frustration, or joy. This may have been the result of feelings that had been bottled up for a long period of time, or a belief by the parents that someone at last understood and cared. Perhaps, it was simply that finally there was a place in which to be heard. Each session proved to be emotionally intense and, as pointed out by some of the parents, very draining. (This writer, also, experienced similar effects.)

3. The quick acceptance by the parents of Elizabeth Kubler-Ross's (1969) five stages of loss was electrifying. The parents literally attached themselves to the concept as it was being discussed. It was as if this concept was a "life jacket" that

encased them. In reality, it seemed to this writer more like a lightbulb that had finally illuminated for them the process in which they had been involved. At that moment, this writer believed they began to accept and understand that life would never again seem fair, or simple or quite as joyous. The parents came back to this concept over and over again. Their communications were filled with Kubler-Ross's terminology. Questionnaire responses and verbal comments were sprinkled with words as "denial", "depression", and "acceptance". Kubler-Ross's theory seemed to make their feelings and behaviors understandable for them. It is this writer's belief that, once things were understandable, they became acceptable. Acceptance is the final stage of the grieving process--the stage that then allows you to go on with your life.

4. The issue of parenting--not the issue of sexual abuse--was substituted and became a healthier bond that held the group together. In setting up the curriculum, this writer knew that behavior management was needed to eliminate the loss of parental self-esteem and competency which is normative for this population. However, this writer underestimated how much it was needed. "Being a parent", which was the cause of their victimization, was also the impetus within this group that allowed them to propel themselves forward. Perhaps these parenting issues were vital because they brought normalcy back

into their frame of reference. The parenting concepts may also have proved to be powerful because the parents began to apply the principles at home and, in seeing results, were immediately reinforced. So the parenting issues became a powerful, positive force within this practicum.

5. This writer had hypothesized that, if this group became cohesive, there might be difficulty in disbanding at the end of the eight-week process. The verbal attempts against ending group were much stronger than anticipated, but paralleled the parents' perceived need for the group. What was not expected before implementation was the moving outward to other parents, either in a group-advocacy position or as individual parent-peer supporters. The transition in eight weeks from "self" and "my pain" to "others" and "alleviating their pain" was a quantum leap.

6. The importance to the victimized children of their parents' being in group was also underestimated by this writer. To have the focus taken off the child as the "sick one", the "hurt one", or the "bad one" and, to see that parents acknowledged needing help themselves, were important concepts for the victimized children. This adds to the writer's belief that not only do parents need treatment, but that parental involvement in treatment shifts the burden from the child-victim to the family as being victim. This puts the responsibility and

perspective on the entire family. When a tragedy occurs in a family, everyone hurts and everyone must get help and work together. One of the parents suggested that, at some point in the Parent Program, the victimized children should be brought in and become part of the group process. Perhaps, this idea could be extended to not only the parents and the victimized children but also to other siblings and even extended family members.

7. This writer anticipated that an increased knowledge of sexual abuse, plus the opportunity for comparison with other sexually-abused children, would help change the parents' focus from looking at their child as "abnormal" to "normal". What was not anticipated was that, once parents were able to view their children as "normal", they were then able to accept them back into the family. This result was most dramatically seen in the confession of the stepparent, who within the eight weeks of Parent Program attendance, moved from resentment of her stepdaughter's involvement in her life, to acceptance, and then to fear that she "might lose my child".

8. It became evident to this writer that parents needed to be more educated about the processing of sexual-abuse incidents. Although one couple did mention attempting to find help, most parents did not seem to be aware of either the need for, nor the benefits of, professional involvement. Agencies must do a better job of advertising their services for parents.

9. The amount of anger at the legal system was not anticipated nor the intensity in which it manifested itself in this particular group. These parents felt a double victimization: victims first because of the act, and secondly because the legal system seems to favor the criminal and not the victim. There was an intense need on the part of these parents to seek punishment for the offender. Most parents specifically stated their belief that the perpetrator should suffer as much as possible. Group members often used examples of swift justice from Third World nations. This justice was either mutilation or death. These parents believed in the Biblical concept of "an eye for an eye" and, in their own situation, were angry at the humaneness of our legal system. No one in this group believed the perpetrators were "ill" or "had a problem"; they believed them to be "crazy" or "bad" and thus needed to be eliminated. These parents harbored strong retributive rage against anyone who would molest a child. They were most clearly advocates of punishment over treatment and, because of this, often found themselves at odds with today's legal system.

In attempting to summarize this Parent Program and its meanings, it seems best perhaps to do so in the words of the victimized parents themselves. Following are some of the parents' written responses to the "comments" question on the Parent Program Assessment and Evaluation form (Appendix Y).

Parent 1: I loved it. I wish it could go on from here. It really has changed my personal course and helped me to understand all areas much better.

Parent 2: Thank you for asking us to take part in group. Perhaps it would be easier to indicate the areas I did not benefit in.

Parent 3: This has been invaluable! Thank you from the bottom of my heart!

Parent 4: (A picture of a big, happy, smiling face.) Thanks, Barbara.

Parent 5: I don't have words to express how much this group has helped me. Thanks.

Parent 6: I was able to move on in a significant area of my life. I had been stuck in the denial level for a year. Now, after moving on in this area, I am moving on in many other areas of my life. Thank you.

Parent 7: There is a lot I would like to say, but I don't know how. Just thank you, Barbara. In three years of hell, for eight weeks I have seen light at the end of the tunnel.

It is the inclusion of parents in the treatment process, that may be one of the most important ways to insure that children suffer less from the potential effects of child sexual abuse.

RECOMMENDATIONS

This writer recommends the following:

1. That there should be more awareness from the professional mental-health community towards the needs of victimized parents.

2. That this awareness manifest itself in the creation of specific and appropriate mental-health programs.

3. That assertive measures be taken to insure that the designated parent population has awareness of these opportunities.

4. This practicum will now become an ongoing program offering by this writer's office. Plans are already underway to replicate this program for another group of parents of extrafamilial sexually-abused children.

5. Any necessary legal forms be devised so that the parents of this practicum who have formed their own advocacy group called "Lifeline" as support for other victimized parents be allowed to do so.

DISSEMINATION

All Child Study Team clinicians at this writer's office have asked to read this completed practicum. Specifically, they have discussed wanting to increase their own knowledge of parental dynamics as an aid in their ongoing work with the child sexual abuse victims. This writer hopes to send an abridged version of this practicum to other mental-health facilities that specialize in child sexual abuse. It is hoped that this will be an incentive to recognize parents' needs and offer necessary

programs.

As a result of hearing about this Parent Program, the local Child Protection Team has inquired about the possibility of this author leading the Parent Program for the parents of their preschool sexually-abused population of children. If a population cannot be gathered from their parents, the Child Protection Team would be interested in making parent referrals to any ongoing parent group at this writer's office.

All professional staff at the local psychiatric inpatient facility where this writer is on staff will receive information regarding practicum results. Also, the hospital will receive specific dates for future Parent Programs at this writer's office in an attempt to provide as many supportive services as possible for their patients.

This writer's practicum verifier has been commissioned to write a book on child sexual abuse. As a result of this practicum, this writer has been approached about the possibility of co-authoring a chapter in this book regarding parental reactions to the sexual abuse of their children.

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APPENDIX A

PARENT PROGRAM DATA AND QUESTIONNAIRE FORM

APPENDIX A

PARENT PROGRAM DATA AND QUESTIONNAIRE

(To maintain confidentiality, do not give your name.)

1. Sex: Male _____ Female _____ 2. Age _____

3. Married _____ Separated _____ Divorced _____ Widowed _____

4. Number of children in family _____

   List ages _____

5. Do you work Full time ___ Part time ___ Do not work ___

6. What is your job title? _____

7. Please check highest educational level you have completed:

Grammar school		_____
High school		_____
GED		_____
College:	Associate	_____
	Bachelor	_____
	Master	_____
	Doctorate	_____

8. Is your income in the range of: Less than $15,000 _____

   $15,000-$25,000 _____ Above $25,000 _____

Specific to Sexual Abuse

9. Current age of abused child _____

10. Age of child when abuse occurred _____

11. Sex of abused child: Male _____ Female _____

12. Your relationship to child: Biological parent _____

    Stepparent _____ Adoptive parent _____

13. Who disclosed the sexual abuse? _____

14. How long after abuse was abuse disclosed? _____

Parent Program Data and Questionnaire

15. To whom was the sexual abuse reported? Police _____

HRS _____ Not reported _____

16. Degree of violence: None _____ Verbal threats _____

Physical force _____ Genital tearing _____

17. Relation of sexual abuser to child: Not known _____

Stranger _____ Trusted neighbor _____ Friend _____

Familial/Relative _____ Biological parent _____

18. Degree of sexual contact: Pornography _____

Exhibitionism _____ Rape _____ Fondling _____ Oral _____

19. Before the child's victimization, had you ever talked to your child specifically about sexual abuse? Yes ____ No ____

20. Did you know what sexual abuse was prior to the sexual-abuse incident? Yes _____ No _____

21. Did you understand how sexual abuse affects children: Yes _____ No _____

22. Does sexual abuse affect children? None _____ Some _____ A lot _____

23. Do you feel overwhelmed by this sexual abuse? Yes _____ No _____

24. Do you feel that the sexual abuse has increased your stress in:

Family life	Yes ____	No ____
Work	Yes ____	No ____
Self	Yes ____	No ____
Relationship with significant others	Yes ____	No ____
Relationship with abused child	Yes ____	No ____
Relationship with other children in family	Yes ___	No ___

25. Do you feel that you have had an opportunity to express your feelings about the sexual abuse? Yes ___ No ___

Parent Program Data and Questionnaire

26. Do you "feel alone" as the parent of a sexually-abused child? Yes ___ No ___

27. Do you feel an adequate personal-support system exists for this problem? Yes ___ No ___

    If "Yes", who is that support? _____

28. Do you feel an adequate community-support system exists for this problem? Yes ___ No ___

    If "Yes", what is that community system? _____

29. If support services for your problem existed and you needed them, would you use them? Yes___ No ___

30. When the sexual abuse was disclosed, what were your feelings?

    _____

    _____

31. What are your feelings now about the sexual abuse? _____

    _____

    _____

32. When the sexual abuse was disclosed, do you feel you managed the situation? Yes ____ No ____

33. As a parent, do you feel good about the way you've handled the trauma of sexual abuse with:

Yourself	Yes ___	No ___
The abused child	Yes ___	No ___
Other siblings	Yes ___	No ___
Your significant other	Yes ___	No ___

34. Do you feel there was something you as a parent could have done to prevent the sexual abuse? Yes ___ No ___

Parent Program Data and Questionnaire

35. Do you feel that your child will have problems in the following areas due to the sexual abuse?

Emotional	Yes ___	No ___
School	Yes ___	No ___
Social	Yes ___	No ___
Sexual	Yes ___	No ___

What do you feel has been the most serious problem for you as a parent of a sexually-abused child? _____

_____

_____

_____

APPENDIX B

INFORMAL CONSENT TO PARTICIPATE

APPENDIX B

INFORMED CONSENT TO PARTICIPATE

This letter is to inform you and to ask for your release of information and participation in a Parent Program. This program is being done by me, Barbara S. Bernbaum, M.A., as a research project to fill the requirements for my Ed.D. in Early- and Middle-Childhood Development through Nova University.

The research is intended to provide training and education for parents of extrafamilial sexual-abuse victims. The program basically consists of an 8-week parenting course which will be held once a week for approximately two hours. At the beginning and end of the course, there will be a questionnaire given. This is basically a set of questions being asked in regard to attitudes, feelings, management issues relative to parenting the victim of sexual abuse. All information obtained will be number-coded and kept confidential by this researcher. All data obtained through this program will become part of the evaluation. Any demographic data and such will be disguised so that no data could be identified to any specific subject's name. Primarily, the program is an educational service-type program.

I, _____, agree to participate in the research program presented by Barbara Bernbaum and fully understand the nature of the research. I am in agreement with her using the data in her research in a competent fashion.

_____ _____

Date Signature of Participant

_____

Signature of Researcher

APPENDIX C

SYLLABUS

APPENDIX C

EXTRAFAMILIAL SEXUAL ABUSE PARENT PROGRAM

SYLLABUS

Session I Sept. 10	Introduction of Program Definition and Spectrum of Child Sexual Abuse
Session II Sept. 17	Myths of Sexual Abuse Sexualization of Normal Developmental Issues
Session III Sept. 24	Effects of Sexual Abuse on Child/Parent/Family
Session IV Oct. 1	Parental Fears and Responses Resources for Coping with Stress
Session V Oct. 8	Discipline that Develops Responsibility Parent-Child Communication
Session VI Oct. 15	Limit Setting The Use of Time-Out and Behavioral Contracts
Session VII Oct. 22	Protecting Your Child
Session VIII Oct. 29	Final Session: Review Let's Talk

TIME: Wednesday evenings, 7:30-9:30 p.m.

FACILITATOR: Barbara Bernbaum, M.A.

APPENDIX D

PARENT INFORMATION LETTER

APPENDIX D

Parent Information Letter

3 September 1986

Dear Parent:

Per our recent telephone conversation, I am enclosing specific details about the parents' group for children who have been sexually abused.

Each of you have been the victim of a horrible trauma and each of you, until this time, has found no support. It is my hope that this parent group will be a new beginning for you as parents, your child, and your family. The goal of the group will be to provide:

1. Information that you as a parent will need to assist you in understanding the trauma of sexual abuse and its effects on all family members.

2. Strategies to aid you, the parent, in dealing with your sexually-abused child, other siblings, and even yourself.

3. An opportunity to express your feelings and opinions with other parents who also have had children who have been sexually abused. You no longer need to feel "alone".

The anticipated starting date of the program will be Wednesday, September 10, and will meet weekly for eight consecutive weeks from 7 to 9 p.m. The meeting dates will be: September 10, 17, and 24, October 1, 8, 15, 22, and 29.

There will be a nominal cost of $8.00 per family to help defray the cost of materials and refreshments.

If there are any questions regarding this group, please do not hesitate to call me at the office. I look forward to seeing all

Parent Information Letter

of you on Wednesday, September 10, for what I know will be the beginning of a special time for all of us.

Sincerely,

Barbara S. Bernbaum, M.A.
Licensed Mental Health Therapist

BSB/dl

APPENDIX E

SESSION I: INTRODUCTION, DEFINITION OF THE SPECTRUM OF CHILD SEXUAL ABUSE

APPENDIX E

CURRICULUM FOR EXTRAFAMILIAL SEXUAL-ABUSE PARENT PROGRAM

SESSION 1:
20 Sep 86
7:30-9:30 p.m.

I Introduction and Definition of the Spectrum of Child Sexual Abuse

A. Development and Purpose of Parent Program

B. Objective of Parent Program:

1. Information to assist parents in understanding the trauma of Sexual Abuse and its effect on children, themselves, and their family.

2. Practical strategies and behavorial management in dealing with the sexually-abused child.

3. An opportunity to share with other parents who have also been victimized and the ability to decrease the sense of feeling alone and unsupported.

C. Hand out "Informed Consent to Participate" form, solicit signatures from parents

D. Specific Structure of Parents Meetings

1. Hand out Syllabus.

2. Stress commitment to group attendance.

3. Review specifics of group, i.e., time, place, dates, cost.

E. Hand Out Parent Program Data and Questionnaire Form

II Definition of Extramfamilial Sexual Abuse

"Contacts or interaction between a child and an adult when the child is being used for the stimulation of the prepetrator or another

person. Sexual abuse may also be committed by a person under the age of 18, when that person is either significantly older than the victim or when the perpetration is in a position of power or control over another." - National Center for Prevention and Control of Tape, Department of Health and Human Services.

When this type of child sexual abuse takes place within a child's family or a household, it is technically called "incest". An incest offender can be a blood relative of this child, such as a parent, brother, uncle, grandfather, cousin, or it can also be a person whom the child thinks of as a family member, such as a stepparent, stepbrother, or even somebody else living in the child's household.

III Spectrum of Child Sexual Abuse

A. Types

1. Non-Touching

a. Verbal Abuse:

Purposeful discussion of sexual acts designed to arouse the child's interests, shock him or her.

An overexposure to sexual words and ideas within family by parents, older siblings, or from peer groups.

Results in continued overexposure which produces anxiety, hyperactive behavior, premature interest and exploration of sexuality, confused and bewildered thoughts regarding sexuality by the child.

b. Obscene Telephone Calls

Predominantly, this towards girls.

It does not generally lead to any kind of direct sexual action.

It is, however, very distressing not only to the child but also to the child's family.

The adult caller or adult perpetrator often does not know the victim.

Adolescent perpetrator usually knows the girls.

Results may require brief therapy to talk about the incident and neutralize experience.

The age of the child makes it considerably difficult.

It is often frightening and confusing to a young child and must be talked about.

Calls can be ended by simply hanging up.

However, there is an aspect of fascination which keeps people listening (often because they really expect the caller himself to stop and hang up).

Don't be angry if child does not hang up.

May also think that it is a joke.

Be careful not to increase the guilt of the victim (i.e., "How could you have been so dumb to just stand there and listen?").

c. Exhibitionism/Indecent Exposure

Shock of the child which partially motivates the "flasher".

Usually not dangerous and does not touch or threaten the child.

It can be very frightening, especially to young girls.

One has to be careful to differentiate between self-exposure and nudity by relatives and friends within the home atmosphere.

This, too, can be stimulating and create anxiety (especially in males where this could produce an erection).

d. Voyeurism ("Peeping Toms")

Gratification is derived from observing the sexual organs or sexual acts of others.

This could be done by a stranger. This could be done by a family. (Recent disclosure of a doctor who watched patients disrobing, watched female patients urinating.)

Usually not dangerous.

The act of being spied upon can be very upsetting and frightening to anyone, in particular a child.

Talk to the child so that the child's fears can be put aside.

e. Primal Scene/Witnessing Intercourse

Visual or auditory exposure to adults having sexual relations.

Mixed controversy: Is it/Is it not harmful?

Freud believed that to view this act, especially with one's parents, set the seeds for neurotic or psychopathological response which could lead either to sexual repression or immature sexual activity.

Many contemporary professionals within the area of pschology and sexology do not believe Freuds' perspective.

However, parents usually feel angry and/or guilty. This can often set up some parenting problems with the child.

This is generally not considered sexual abuse, when it is accidental.

Must be prevented and parents must take precautions to either lock their door to to be discreet in their lovemaking.

Results: If this happens, take time to talk to the child.

Reassure your child that love is good; that it is a natural outgrowth to people who love each other and are committed to each other.

Encourage the child to express his/her feelings.

Oftentimes a younger child will feel as if Daddy is hurting Mommy.

Must allow ventiliation of child's feelings so that parent can explain what really is occurring.

2. Touching/Bodily Contact Between Adult and Child

a. Kissing:

This would be adult kissing a child in a lingering, intimate way.

b. Fondling:

Adult fondling a child's breasts or genitals.

Child fondling adult at request of the adult.

c. Masturbation:

Adult masturbation while child watches.

Adult observes child masturbating.

Adult and child observe each other while self-masturbating. (This is mutual masturbation.)

d. Fellation:

Adult has child fellate him or adult will fellate child.

e. Cunnilingus

This is oral-genital and requires mouth-to-vaginal-area contact.

f. Digital

Finger penetration of the anus, or rectal opening, or of vagina.

g. Penal Penetration:

In the anus, or rectal opening, or in the vagina.

An "eye dry" intercouse. This is a slang term for rubbing penis against genital or rectal areas.

3. Violent:

All the touching sexual abuse can include physical abuse.

Physical threats, beatings, torture. This can result in murder.

Violent sexual abuse can be forced upon the child by:

Taking advantage of someone younger.

Children are taught to obey adults.

Bribery in a hundred different ways.

"I'll let you watch T.V. until midnight, if..."

Threats.

Harm to the child. "You'll get it if you tell!"

Harm to the offender. "If you tell anyone, I'll go to jail."

Withdrawal of affection.

"I won't love you anymore."

Breakup of the family.

"It would hurt Mom."

Taking advantage of child's lack of knowledge.

"It's okay. Everyone does it." "Daddy's going to show you how the doctor's going to examine you when you go to the doctor next week."

A. Pornography and Prostitution

Exploitation of children for economic gain.

B. Rape

Child fortunate to be alive but the trauma of sexual abuse plus physical abuse is enormous.

Studies how raped child may unconsciously allow thier own child to be victimized.

Seem to have a need to report the traumatic sex act over and over.

Separation of aggression and sexual development tears apart the child. (They never feel they are whole again.)

Ordinary experiences become traumatic.

Curriculum for Extrafamilial Sexual-Abuse Parent Program

Never underestimate the need for treatment and may have to be repeated several times throughout the victim's lifetime.

C. Murdered Child

Statistically the result of a sexual assault.

IV Parent Discussion

APPENDIX F

SESSION II: MYTHS OF SEXUAL ABUSE AND SEXUALIZATION OF NORMAL DEVELOPMENT ISSUES

APPENDIX F

CURRICULUM FOR EXTRAFAMILIAL SEXUAL-ABUSE PARENT PROGRAM

Myths of Sexual Abuse and Sexualization of Normal Developmental Issues

SESSION 2: I Sexual-Abuse Questionnaire
17 Sep
7:30-9:30 p.m.

A. Parents take questionnaire.

B. Review and discuss Questionnaire with parents.

1. Abuser is a weird stranger. F

   - Person is known, often relative, friend of family.

   - 85% of sexually-abused children know their abuser.

2. Abuse happens just once. F

   - Usually continuous, over and over and over.

3. Sexual abuse suddenly happened out of the blue. F

   - Develops gradually over time.

4. Sexual abuse is a rare and extreme phenomenon. F

   - It frequently occurs and there are many forms of sexual abuse.

5. Sexual abuse is always a violent act. F

   - It usually has subtle overtones rather than extreme forces.

6. Very few physical abusers of children are mentally ill. T

- Not psychiatrically, not a thought disorder. Know difference between right and wrong.

7. Boys are not often victims of sexual abuse. F

   - Social stigma prevents disclosure of abuse (homosexuality).

8. Infants and toddlers are not victims of sexual abuse. F

   - There is no age barrier to sexual abuse. Sexual abuse has been found with newborn infants to women in their 90s.

9. Women are not abusers or victimizers of sexual abuse. F

   - Women have not been reported in the same numbers as men.

   - Different forms of sexual abuse.

   - A more subtle form.

   - Still safeguarded by society.

10. There is no potential for change in a sexual-abuse family. F

    - Treatment which consists of a combination of individuals and family using a systems approach.

11. Children make up stories and fantasize about having sex with adults. F

    - Usually never.

    - Children do not have in their repertoire the knowledge of certain sexual behavior.

12. Usually only one child in the family is sexually abused. F

    - Multiple or serial abuse.

    - Often each child is told that if he/she cooperates, his/her brother/sister won't be touched.

13. Sexual molestation of child by an adult is not necessarily harmful. F

    - It is dependent on the age, the type of abuse, the direction of abuse, the relationship between victim and the abuser.

14. Incest is violent physical act. F

    - No. It is subtle manipulation of child by a trusted adult.

15. Teens who are sexually active or are promiscuous "ask for it". F

    - No one has the right to touch another person if they do not want to be touched.

16. Statistically, physically-handicapped children are more likely to be abused than the non-physically-handicapped. F

    - No. Every one is equal, if the abuser needs a victim.

17. Many child abusers were themselves abused as children. T

    - Yes.

    - Learned behavior.

    - Repetitive pattern.

18. Child abuse is more prevalent among the poor and minority groups, according to recent research. F

    - No. There is no economic status for child abuse.

    - Child abuse is found equally in all socioeconomic brackets and among all races.

19. Sexually-abused children are incapable of carrying on a normal sexual relationship as adults. F

    - Proper treatment.

    - Patience and understanding.

20. Children who are victims of abuse are frequently stigmatized by parents, peers, and the community. T

    - Yes. They become double victims.

    - The "used-goods" syndrome.

21. Admission of guilt by the adult abuser usually occurs quickly in most cases. F

    - No. (Personal experience.)

II <u>Sexualization of normal developmental issues.</u>

- Parents sexualize what is normal because of sexual abuse.

A. <u>Normal sexual development may include:</u>

1. Sexual identity

2. Masturbation

3. Sex play

4. Sex questions

B. Abnormal sexual development may include:

1. Verbalization

2. Sexual acting-out

C. Impact of sexual abuse on normal sexual development.

a. Effect of sexual abuse on child's normal sexual development may include:

1. Guilt
2. Fear
3. Confusion
4. Anger
5. Blurred-role Boundaries
6. Pseudomaturity
7. Lack of self-control

D. Effects of sexual abuse on parents' view of child sexually:

1. Feelings about sexual abuse are ours as an adult - may not be child's.

- They have different perception of sexuality.

- This difference causes conflicts, stresses, many misunderstandings.

2. May cause interference or problems with parents' own sexuality.

- Often sexual problems between parental couples.

3. Difficulty differentiating between normal development issues and sexual-abuse issues.

Curriculum for Extrafamilial Sexual-Abuse Parent Program

III Parents' Discussion:

- What's appropriate/accepted sex behavior and what is not. (Brainstorm list with parents on board.)

IV Handouts: Advocacy Programs:

- Channel energy into positive direction.

APPENDIX G

SEXUAL ABUSE QUESTIONNAIRE

APPENDIX G

SESSION 2 SEXUAL-ABUSE QUESTIONNAIRE
(Please circle T or F for each question)

T F 1. The abuse is usually a weird stranger.

T F 2. Sexual abuse happens just once.

T F 3. Incestuous sexual abuse suddenly happens out of the blue.

T F 4. Sexual abuse is a rare and extreme phenomenon.

T F 5. Sexual abuse is always a violent act.

T F 6. Very few physical abusers of children are mentally ill.

T F 7. Boys are not often victims of sexual abuse.

T F 8. Infants and toddlers are not sexual-abuse victims.

T F 9. Women are not abusers or victimizers.

T F 10. There is no potential for change in a sexually-abusive family.

T F 11. Children make up stories and fantasize about having sex with adults.

T F 12. Usually only one child in a family is sexually abused.

T F 13. Sexual molestation of a child by an adult is not necessarily harmful.

T F 14. Incest is a violent physical act.

T F 15. Teens who are sexually active or are promiscuous "ask for it".

T F 16. Statistically, physically-handicapped children are more likely to be abused than non-phyically-handicapped children.

Sexual-Abuse Questionnaire

T F 17. Many child abusers were themselves abused as children.

T F 18. Child abuse is more prevelant among the poor and minority groups, according to recent research.

T F 19. Sexually-abused children are incapable of carrying on normal sexual relationships as adults.

T F 20. Children who are victims of abuse are frequently stigmatized by parents, peers, and the community.

T F 21. Admission of guilt by the adult abuser usually occurs quickly, in most cases.

APPENDIX H

HANDOUT: MOTHERS AGAINST DRUNK DRIVERS

MADD
SUPPORT & INFORMATION LITERATURE NOW AVAILABLE!

STUDENT INFORMATION PACKET
Informs students about starting their own programs; also includes research on teen drinking, other orientation materials.

MADD GENERAL INFORMATION KIT
Includes detailed information on the history and mission of MADD, along with a brief overview of Founder Candy Lightner and MADD's many community outreach and public education programs.

MADD MEMORIAL GIFT PACKET
Sample cards and envelopes which allow individuals to make a donation to MADD on behalf of or in memory of a friend.

ARRIVE ALIVE KIT
Includes a MADD sticker, decal, REDD Alert card, BAC chart, and Emergency Assistance card.

VICTIM INFORMATION PAMPHLET
28 page booklet containing the facts victims need to help them NOW.

YOUR GRIEF: YOU'RE NOT GOING CRAZY
28 page booklet oriented towards the individual.

THE UNIQUE GRIEF OF PARENTS
28 page booklet directed at parents and their needs.

HELPING CHILDREN COPE
Booklet for children and those who will help them cope.

"21 BINDER"
100-plus page document concerning the legal drinking age.

OTHER BROCHURES AVAILABLE INCLUDE:
- Victim Rights in Alcohol Impaired Crashes
- Supporting Those You Love
- 9 Things To Do To Help MADD
- That's Why We're MADD

MADD

Your donations make it possible for MADD to provide victims with services and publications.

Help MADD help you!

I Am

- ☐ A Victim
- ☐ Concerned Citizen
- ☐ Interested in Volunteering

Name _____

Address _____

City & State _____

Zip _____

Phone No. (_____) _____

Total Amount Enclosed $ _____

THANK YOU!

Please send to: Your local chapter, or if no local chapter is in your area, send to:

MADD
c/o Victim Services Department
669 Airport Freeway, Suite 310
Hurst, Texas 76053

MADD
PUBLICATIONS

VICTIM PUBLICATIONS
(one copy available to victims free on request)

	Quantity	Total
Victim Information Pamphlet	_____ @ $1.00 =	_____
Your Grief: You're Not Going Crazy	_____ @ $1.00 =	_____
The Unique Grief of Parents	_____ @ $1.00 =	_____
Helping Children Cope	_____ @ $1.00 =	_____
Victim Rights in Alcohol Impaired Crashes	_____ @ .50 =	_____
Supporting Those You Love	_____ @ .50 =	_____

(your donations make victim copies available FREE)

MADD SUPPORT LITERATURE
(Available through MADD Council Offices)

9 Things To Do To Help MADD	_____ @ $ .50 =	_____
That's Why We're MADD	_____ @ $ .50 =	_____
"21" Binder	_____ @ $15.00 =	_____
Student Information Packet	_____ @ $4.00 =	_____
MADD General Information Kit	_____ @ $3.00 =	_____
MADD Arrive Alive Kit	_____ @ $4.00 =	_____
MADD Memorial Kit	_____ @ $2.00 =	_____

MADD MEMBERSHIPS

$10.00 Senior Citizen/Student Member	=	_____
$20.00 Individual Member	=	_____
$40.00 Family Member	=	_____
$150.00 or more Organization Affiliate	=	_____

DONATIONS
(Donations are Tax-Deductible)

$ 20.00 Donation	=	_____
$100.00 Donation	=	_____
Other _____		_____
SUB TOTAL		$_____
HANDLING		$1.00
TOTAL		$_____

REMIT WITH ORDER

APPENDIX I

HANDOUT: SUNNY VON BULOW VICTIM ADVOCACY CENTER

Sunny von Bulow National
Victim Advocacy Center
307 West 7th Street, Suite 1001
Fort Worth, Texas 76102

SUNNY VON BULOW

NATIONAL VICTIM ADVOCACY CENTER

307 West 7th Street, Suite 1001
Fort Worth, Texas 76102
(817) 877-3355

The U.S. Department of Justice estimates that one out of three American families will be victimized by a violent crime this year alone. This is a horrifying statistic — one which tears at the very seam of the fabric of American society.

For five years, we were deeply involved in a widely publicized trial concerning a tragedy which left our mother, Sunny von Bulow, in what doctors say is an irreversible coma. Throughout the trial, we were made painfully aware of the inadequacies of our justice system. As a result of our firsthand experience, we have committed our energies to advocate for the rights of violent crime victims.

The Sunny von Bulow National Victim Advocacy Center promotes responsiveness of the judicial system to the rights and needs of victims of violent crime, and implements programs to heighten America's consciousness concerning the plight of victims. The Center will serve as a national resource data bank, providing victims and their allies with up-to-date information on victims' rights and criminal justice issues.

In addition, the Center will work to build a nationwide network of victims and advocates, building a strong, cohesive foundation upon which to mobilize national support for victims' rights causes.

Although the Center will never bring our mother back, perhaps it will help guarantee that victims and their families will not have to experience the same tragedy, the same sorrow, and the same frustration that our family has endured. The ambitious goals of the Center present a tremendous challenge to the silent victim, to the criminal justice system, and to concerned citizens who believe in our right to a safe and peaceful environment. We wholeheartedly accept this challenge, and invite the American public to likewise commit its full support for the rights and needs of victims.

ALA KREISSL ALEXANDER VON AUERSPERG

PROGRAMS AND SERVICES

A National Coalition of Victims

A priority of the Center is to create a nationwide coalition of victims and their advocates to increase efforts that mobilize support for positive change in the perception and treatment of violent crime victims.

National Resource Data Bank

Information on victims' rights, legislation, reparation, criminal justice, and the implications of victimization is available to victims, their advocates, and other concerned citizens.

Public Awareness

Programs and activities sponsored by the Center strive to increase America's awareness of the tragedy of crime victims, and create widespread support for improved victims' programs and services.

> *"Justice will be served only when those who are not injured by crime feel as indignant as those who are."*
>
> *— Solon*

> *"Can I see another's woe, and not be in sorrow too?"*
>
> *— William Blake*

Community-Based Victim Programs

Victims advocates who require guidance to initiate grass-roots service programs for victims will receive on-going assistance from the Center, including needs assessment development, skills training in public outreach, and other skills development tools necessary to empower victims.

Education for Activists

A comprehensive education program sponsored by the Center works to increase effectiveness of volunteers in critical areas such as communications, leadership, legislative action, court monitoring, organizational development, victims' rights, and victims' support programs.

Volunteers for Victims

The Center encourages citizen involvement in victims' rights programs by disseminating information to potential advocates about the criminal justice system, helping victims cope with grief, assisting elderly or handicapped victims, and advocating for victims' rights.

Program Development Grants

The Center provides resources to grass-roots victims' groups to develop programs which serve victims of violent crime.

Information and Referral

The Center refers violent crime victims to appropriate services and programs on an ongoing basis, utilizing the network of the national coalition and grass-roots victim advocacy programs.

> *"Justice is not social, economic, or political. It is all of them. Justice is justice, plain and unqualified. . . . If limited to a class, it is no longer justice. Every citizen, not merely a class, is entitled to justice."*
>
> *— Arthur M. Hyde*

Name: Mr. / Mrs. / Ms. _____

Affiliation (if any): _____

Mailing Address: _____

_____ Zip _____

Telephone Number: (area) ( ) _____

I am a: ____ Victim ____ Victim Advocate ____ Survivor ____ Victim Service Provider ____ Concerned Citizen

I would like to: ____ Be added to the Center's mailing list

____ Volunteer in my community

____ Other (please indicate) _____

I would like to make a contribution to the Survey von Bulow National Victim Advocacy Center (all donations are tax-deductible)

____ $250.00 ____ $100.00 ____ $50.00

____ $25.00 ____ $10.00 ____ Other $ _____

Please detach this form and mail it (with your check, if applicable) to the Survey von Bulow National Victim Advocacy Center.

Thank you for your support!

APPENDIX J

SESSION III: THE EFFECTS OF SEXUAL ABUSE ON CHILD/PARENT/FAMILY

APPENDIX J

CURRICULUM FOR EXTRAFAMILIAL SEXUAL-ABUSE PARENT PROGRAM

SESSION 3
24 Sept

Effects of Sexual Abuse on Child/Parent/Family

I Magnitude of Effect on Child

This is dependent on:

1. The age of child at onset of abuse.
2. Duration of the sexual abuse.
3. The type of abuse.
4. Relationship with the abuser.
5. Family support.

Mother and son incestuous sexual abuse which would perhaps be long ongoing with much frequency which would entail full intercourse with an adolescent would have severe effect on the child that might be on one end of the continuum. On the least end might be a one-time incident with a young child with an exhibitionist.

II Behaviorial Indicators of Sexual Abuse are found in the three realms of physical, social, and emotional.

1. Regressive behavior.

   Wetting the bed. Being afraid of the dark. Being alone. Behaviors that they have already outgrown.

2. Overly-compliant behavior.

   Doing everything that you, the adults, ask them to do.

3. Self-mutilation.

   Picking at one's self until one makes sores and they bleed.

   Cutting on one's self.

   Scratching one's self with a pencil point.

4. Sleep disturbances/bad dreams.

   Unable to fall asleep. Waking up early. Having nightmares.

5. Anxiety.

6. Suspicion of everyone and everything.

7. Running away from home.

8. Withdrawal from friends, family. Spending to much time alone. (One has to be aware of what is normal behavior, i.e., adolescents will need and begin to spend more time alone.)

9. Lack of trust of significant others.

   Crying they don't want to go to Daddy's to spend the weekend in a separated or divorced family.

10. Non-participation in school/social activities.

11. Unwillingness to participate in physical/recreational activities.

    There may be body pain. They may have a body image of themselves.

12. Poor peer relationships or inability to make friends.

They feel different. They know something is different about their life. They feel stigmatized. They feel they're bad.

13. Depression (clinical)

    Stays no matter what. Unable to find any joy in life.

14. Confusion.

15. Substance abuse (drugs/alcohol).

16. Suicidal feelings/attempts.

17. Inability to concentrate at school.

    Sudden drop in school grades.

18. Inexplicable medical problems.

    Somatic complaints that can't be verified. Stomachaches. Headaches.

    Complaints and the doctor does not find anything wrong.

19. Acting-out aggressive behavior.

20. Pseudomature behavior.

21. Persistent and inappropriate sexual play with peers, toys, or themselves.

22. Sexually-aggressive behavior with others.

23. Detailed and age-inappropriate sexual behavior and knowledge.

    Sexual knowledge beyond their years.

24. Delinquent behavior. Truancy. Talking back to teachers. Shoplifting. Stealing.

25. Seductive behavior with males. (Male perpetrator and female victim.)

26. Extraordinary fear of males.

    Generalization to all males. (Male perpetrator and female victim.)

27. But the most important effect of sexual abuse on children is children's fear that they will lose their parents' love and support.

III Effects of Sexual Abuse on Siblings: (Brainstorm List)

a. Parents doubt their ability to parent.

b. Exhausted because of their anger/grief emotions and don't have energy to interact or discipline other children.

c. Children jealous of attention sibling is getting.

d. Parents realize can't give to siblings; send them away to other family members. Children feel rejected.

e. Siblings may exhibit behavior problems at home/school as they attempt to deal with their feelings.

f. Overprotection of siblings as compensation for sexual abuse of other child. May cause parent-child conflicts.

g. Siblings are pressured to take care of parents and parental anxieties.

h. Children guilty over feelings towards sibling.

Curriculum for Extrafamilial Sexual-Abuse Parent Program

IV Effects on Family:

a. Financial loss because parents have difficulty coping with work and its pressures.

b. Families abandon religion/social gatherings/other people and become more isolated.

c. Some families refuse to talk about the trauma. Each person is left to grieve by himself. Becomes a consuming process. Can't support each other when no one is there to support you.

V Effects on Marital Couple:

a. Severe stress on couples often resulting in separation/divorce. Difficult to grieve and support simultaneously. Grief makes a person self-centered, unable to support spouse.

b. Grief process different for each parent (new week Kubler-Ross). Usually in a different stage of grieving. Neither understands the other. Creates stress, tension between couple. Each must be allowed freedom to grieve.

c. Differences in how to proceed with the situation causes severe stress. Should child be involved in treatment? Should child be involved in court?

d. Jealousy towards "perceived" ability of other spouse to either handle situation better or because one has "work" which looks as if it preoccupies spouse from dealing with trauma.

e. Couples often have intense rage - rage at situation, society, God, other parents, police, etc. Anger is often placed on

spouse unfairly because they are easy targets. Often devastating for the recipient. Recipient has little energy with which to cope.

f. Couples may blame each other for tragedy. Must be discussed rationally and openly so feelings can appropiately surface. Anger distances marital couple from each other.

g. Sexual relationships become problematic. Complicated issue due to each parent's personal view of sexuality. Couple must talk about this and find a solution. Many ways to deal with this issue, but it must be comfortable for both partners. Intimacy is often the issue - not sexuality.

h. Depressed parents are apathetic and have a hard time getting things accomplished. Partner to carry their share of the load.

APPENDIX K

SIGNS OF CHILD SEXUAL ABUSE

APPENDIX K

EXTRAFAMILIAL SEXUAL-ABUSE PARENT PROGRAM

Signs of Child Sexual Abuse

From birth through 3 years of age, a child may:

show signs of physical injury.

show signs of physical illness, possibly related to genital or urinary systems.

become unusually fussy.

refuse his/her favorite food.

become extremely shy.

exhibit a sudden or unusual fear of strangers.

show a lack of enjoyment in his/her favorite playthings.

cling to parents as if fearful.

experience great difficulty getting to sleep.

exhibit extreme fear of being left alone.

suffer from frightening dreams.

regress to an earlier pattern of behavior.

show a regression of skills.

experience a loss of his/her sense of security.

become unable to adjust to his/her normal schedule.

manifest any change from his/her normal behavior pattern.

From age 4 through 12:

exhibit signs of physical injury.

manifest signs of physical illness, with a variety of symptoms

from recurrent headaches, upset stomach, or urinary-tract infection.

exhibit sudden extreme shyness.

suffer from frightening dreams.

experience great difficulty getting to sleep.

refuse his/her favorite foods.

suffer from depression.

exhibit some loss of memory.

worry excessively, interrupting his/her normal life pattern.

exhibit a change in his/her level of scholastic achievement.

exhibit fear of specific adults.

have a sudden and unwarranted fear of the dark.

exhibit extreme fear of being alone.

show a regression in patterns of behavior or skills.

exhibit a change in school relationships, including possible fighting and the sudden inability to adjust.

show a lack of enjoyment of his/her favorite T.V. shows, movies, games, or other activities.

seem easily distracted as though his/her mind is wandering.

manifest a change in his/her normal attitude.

manifest a change in his/her pattern of normal behavior.

act out in a sexual manner, appearing more knowledgeable about sex than his/her peers.

develop a pseudomature character, taking over specific parental responsibilities in the home (a sign predominantly associated with incest).

Extrafamilial Sexual-Abuse Parent Program

From age 13 through 19, a teenage may:

manifest signs of physical injury.

manifest signs of physical illness, headache, stomach cramps, urinary-tract infections.

suddenly refuse food.

suffer from sudden and violent frightening dreams.

manifest difficulty in getting to sleep.

seem in the depths of depression.

exhibit an inability to concentrate.

show irritability or manifest angry outbursts toward others.

exhibit a sudden and unwarranted fear of the dark.

have a sudden lapse of enjoyment of dating.

feel an unexplainable fear of being left alone.

worry excessively, interrupting his/her normal life patterns.

experience a loss of memory.

exhibit fear of specific adults.

exhibit a change in his/her level of scholastic achievement.

act out the sexual encounter with siblings or friends.

experience a lack of enjoyment for his/her favorite activities.

make an attempt to run away from home.

contemplate suicide.

appear passive or overly compliant in behavior.

behave seductively with the opposite sex.

manifest a deviation from his/her normal behavior patterns or attitudes.

(Excerpted from Protect Your Child A Parent's Safeguard Against Child Abduction and Sexual Abuse, Huchton, L. (1985).

APPENDIX L

SESSION IV: PARENTAL RESPONSES

APPENDIX L

CURRICULUM FOR EXTRAFAMILIAL SEXUAL-ABUSE PARENT PROGRAM

SESSION 4
1 Oct 86:
7:30-9:30 p.m. I Parental Responses

Responses

Parental responses and reactions play a large role in shaping the child-victim's reponses.

Child's reactions/recovery cannot be separated from the family dynamics. That is, reactions are bidirectional.

The significance of parental reactions to the child's future ability to integrate and recover from the abuse cannot be underestimated.

A. Kubler-Ross: Five Stages of Loss. The way in which parents respond to the sexual abuse is due to the following:

1. Parents' past history to experiences as children.

2. Relationship with their parents.

3. Closeness to each other/significant other.

4. Personal issues with sexuality.

B. Kubler-Ross: The Loss Process. Parents of sexually-abused children are grieving over the "loss" of their child. Five stages: denial, anger, depression, bargaining, and acceptance. Everyone goes through it. Everyone at their own pace. Couples in different stages.

C. Parental Behavioral Response.
Parents' emotional and physical responses and symptoms to the sexual abuse of their child are typical, catastrophic reactions. (This would be the same

responses the parents would have to any catastrophe in their lives.)

1. Anger and Revenge

Intense rage at perpetrator. Father often believes that children, especially females, are property of the father: property-holder's revenge. "Something of mine has been abused."

Women who identify with the same sex, the feeling is: "I have been violated".

If physical abuse is also present, rage is so uncontrollable that it could conceivably turn the family upside down. Thoughts of revenge serve to help negate the parents' own feelings of helplessness.

However, the victim then has an extra burden of trying to calm, placate, or reassure or deny her true feelings to her parents. They feel as if they have harmed you and won't confide in you again.

Do something constructive with your anger, such as ventilate it, cooperate with authorities, file a suit on behalf of your child, develop a preventative program.

2. Helplessness

Want to "undo the effects of sexual abuse" on their child themselves.

Loss of control has the parents attempting to relieve their frustration and they turn to clergy, friends, caretakers, police, etc.

Victims feel parents are invasive into their world and are further serving to humiliate them by making the trauma public knowledge.

3. Guilt
Parents feel as though they failed in their duties as protectors. Interpersonal parent-child difficulties may have caused the child to place themselves at greater personal risk or allowing the child to become an easier victim. (Example: run away from family argument and is raped.)

Parents feel guilt and responsibility for abuse.

The "if only..." feeling predominates.

It's useless to your child and unproductive for you.

Leave the anger where it belongs - on the abuser - not on yourselves or on your child.

4. Blame
Directed at victim. "Why weren't you more careful?"

"Didn't I tell you a million times not to go there alone?"

"Didn't you realize what you looked like in that dress before you left the house?"

Emphasis on the sexual aspect of the crime and not on the trauma or the violence the victim has experienced. Victim is never given credit for escaping the situation with his/her life.

Blame needs to be directed at the abuser - not at the child.

5. Denial/Minimization

Parental denial takes many forms: denying the incident occurred; denying the details of the experience; denying the impact on the child. (Denial is appropriate on some levels. It allows one to become used to the trauma but, used in excess, is not okay.)

The reasons are very complex why parents deny or minimize.

1. Sometimes there is a non-supportive relationship between parent and child,
2. and the need to defend against one's own feelings of sexual violation/sexual vulnerability.

There may be strong denial of the parents' need because they feel they can't cope with the situation or the pain.

Most often minimization by parents is seen in the bypassing of the legal system.

A 1981 report in Boston reported only 50% of parents reported the sexual abuse of their child.

C. Parents Fears for their Sexually-Abused Child- After Abuse

1. Development of emotional problems.
2. Fear of sex.
3. Fear of adults.
4. Development of School Problems.
5. One-third of all parents were frightened that their child would become homosexual.

6. Withdrawal by Father
   Child feels as if they did something wrong/they are bad.
   Keep touching and hugging - at first uncomfortable, but it will pass.

II Inappropriate Parental Coping Methods - Normal - but set up other problems

A. Patronization/Overprotection
To overcome a sense of guilt prior to abuse, they may now suggest new curfews, being accompanied by an adult or by an older sibling.

This feeds into the helplessness or dependency already being felt by the victim. Creates a parental-child conflict in normal developmental individuation and self-identity growth of the child (particularly adolescents).

Victims must begin to use adoptive strategies to enhance their self-esteem and autonomy.

Your fears may undermine the child's need to establish self-sufficiency and could actually increase their vulnerability to others.

B. Distraction
"Time heals all wounds" phenomenon.

Time should go by quickly and painlessly. (New gifts, vacations.)

So the child won't have to think about the trauma and time will go by and it will be all better.

Normal parental response, but it denies the child victim of much-needed ability to talk about the abuse (catharsis).

It also does not allow the child to grieve and mourn the sexual-abuse trauma. Grieving and mourning must be done before one begins to heal.

C. Protective Silence

Perceived or believed stigma of sexual abuse overwhelms parents.

They feel embarrassed by the abuse.

You project into the child parents' feelings and presume the child is also humiliated or embarrassed to talk about it.

So parents then cooperative in "protecting" the child with their silence.

However, children interpret parental silence as shame or disgust over the incident.

Family members need each other through mutual support to work those feelings of abuse through.

The above coping styles tend to negate the victim's attempt at recovery as well as frustrate other family members. The result is increased personal tension.

III Resource for Coping with Stress

A. Quality of Family Relationships

The quality of the family relationships prior to the sexual abuse is well documented in the literature as an important resource for the control of family stability and mutual support.

Sexual-abuse trauma adds stress to vulnerable areas of relationships that were unresolved at the time of abuse. Research shows most likely to be intensified by this additional stress.

Marital problems may arise because the stress of the child's sexual abuse puts a strain on any marriage. But it is particularly difficult if the marriage is already on shaky ground.

Some parents secretly or openly blame the other partner for the trauma. Sometimes parents will have a difficult time having sexual relationships during this crisis.

Where there is a positive, nurturing supporting network, it will continue to be there.

Crisis can serve as a re-evaluation process or a reconfirmation of the quality of the relationship. Example: An adolescent may be surprised at the supportive, non-accusing stance taken by parents.

B. Communication

One of the most important responsibilities for the family is open communication within the family system.

Ventilation of feelings in a non-judgmental environment will help family members realize their underlying negative feelings/attitudes toward the situation.

Feelings of blame and anger are best recognized by all family members.

These feelings are also best externalized to a source outside the family unit. Therapy, counseling support group for parents is so important.

Delicate balance of attempting to ventilate negative feelings and yet offer support to one another.

Must blend both the family and the professional in support during the difficult times.

C. Flexibility

Stress of trauma may prevent the child victim, parental victim from performing tasks or interacting as they did before the abuse.

Family structure may need to change in response to this. Therefore, families which are flexible and can realign roles during the recovery phase of trauma will reduce the amount of conflict.

Rigidity of expecting certain behaviors will only serve to exacerbate the disruption of the unit.

Parent Reminder: There is nothing you can do to change the fact that the abuse has occurred.

- there was probably little you could have done to prevent the abuse.
- there is much you can do to lessen the effects.

Handout: Tips to Help Parents Cope.

APPENDIX M

HANDOUT: TIPS TO HELP PARENTS COPE

APPENDIX M

EXTRAFAMILIAL SEXUAL-ABUSE PARENT PROGRAM

Tips to Help Parents Cope
(Excepted from "The Unique Grief of Parents" - Mothers Against Drunk Driving)

1. Be patient with each other and allow plenty of time for grief and anger to resolve.

2. Focus on the aspect of the situation that is most difficult to bear. Find one solution at a time. Discuss it with the other spouse or child involved.

3. Try to really hear and understand the position of other family members.

4. Talk about the trauma. Do not try to deny that it occurred.

5. It is good for parents and children to cry together. By not letting children see your grief, this may cause them to questions parents' love for them. (However, the total emotional collapse of a parent is not good.)

6. Try not to expect too much from your spouse. When a parent is being fragile or vulnerable, accept him as he is. If a spouse is unable to give support, go to a friend or clergyman.

7. When disagreements occur, try not to vent anger by verbal attacks. Own your own anger rather than blaming your spouse.

8. Even though sexual desire may be waning, spend time tenderly holding each other.

9. Don't let children become the caretakers of the parents. They also must grieve and not "hold up" for the parents.

10. Don't make major family decisions such as moves, job changes, etc., for at least a year. Every change means more stress.

11. If communication is difficult, search for outside support. This may be in the form of counseling, pastoral counseling, parental support groups, etc.

Extrafamilial Sexual-Abuse Parent Program

12. Have patience. Things will get better. It takes patience, hard work, and time. Only a combination of these three will lead into resolution of the pain.

APPENDIX N

SESSION V: DISCIPLINE THAT DEVELOPS RESPONSIBILITY
AND PARENT-CHILD COMMUNICATION

APPENDIX N

CURRICULUM FOR EXTRAFAMILIAL SEXUAL-ABUSE PARENT PROGRAM

SESSION 5:
8 Oct 86:
7:30-9:30

Discipline that Develops Responsibility and Parent-Child Communication

I Reward and Punishment
Discipline system that is most used by parents. Its disadvantages are:

A. makes parents responsible for child's behavior;

B. prevents child from learning to make their own decisions;

C. suggests acceptable behavior is expected only in the presence of authority figures;

D. invites resistance by attempting to force children to conform.

II Natural and Logical Consequences

A. Holds children, not parent, responsible for their behavior.

B. Allows children to make their own decisions about which course of action is appropriate.

C. Permits children to learn from the natural or social order of events. Example: If a child doesn't eat, they go hungry.

D. Logical consequences must fit behavior in a logical way.

III Differences Between Punishment and Natural and Logical Consequences

A. Punishment expresses the power of personal authority. Logical consequences express the reality of the social order. Example:

B. Punishment is arbitrary and barely related to the logic of the situation. Logical consequence related to the misbehavior. Example:

C. Punishment is personalized and implies moral judgment. Logical consequences are impersonal; there is no element or personal or moral judgment. Example:

D. Punishment is concerned with past behavior. Logical consequences are concerned with present and future behavior. Example:

E. Punishment threatens the offender with disrespect or loss of love. It's a putdown. Logical consequence: parent's voice is friendly and implies good will. Example:

F. Punishment demands obedience. Logical consequence permits choice. Example:

IV Basic Principles of Natural and Logical Consequences

A. Understands child's goals, that is, their behaviors and emotions (handout).

B. Be both firm and kind.
Tone of voice indicates kindness.
Firmness is an attitude toward one's decision (parents' decision).
Firmness is shown with our behavior and feelings.

C. Don't try to be a "good" parent.
Refrain from overprotection.
Allow child to experience the consequences of his/her own decision.
A pampered child's worst handicap of all.

D. Become consistent in your actions.
Increase consistency so children know what to expect.
This is one of the most important ingredients in behavior management of children.

E. Separate the deed from the doer.
Respect your child by tone of voice and non-verbal behavior.
You always love your child; it is his behavior that is not socially acceptable.
Behavior does not indicate the worth of a child.
Child always has worth.

F. Encourage independence.
The more self-reliant, the more competent the child will feel.
The more independent, the more prepared for responsible, happy adulthood.

G. Avoid pity.
Parents protect child because they feel sorry.
Pity is damaging and recipient feels inwardly that he/she is defective and cannot handle his/her own problems.
May serve to make an insecure parent feel stronger, but it does so that the child's expense.
Empathy. "We understand your feelings."
This understanding of feelings promotes strength.

H. Don't worry about what other people think.
Can't allow children to accept consequences of their behavior because of other people: other parent, grandparents, people in the supermarket, etc.
Children are independent beings who must learn to decide how they will behave.
Their behavior does not reflect on parents.

Parents cannot possible be responsible for all their children's behaviors.

I. Recognize who owns the problem.
Don't accept kid's problems.
Extricate yourself from their dilemma.
Define who owns the problem.
Help guide. But it is their reponsibility. (Most often seen in school-related issues.)

J. Talk less; act more.
Child becomes "parent deaf".
Don't talk when angry.
Keep talk to minimum.
Follow through with action.

K. Refuse to fight or give in.
Set limits and allow child to decide how to respond to them.
Be willing to accept child's decision, even if it is a tantrum.
You don't have to win.
Children should become responsible for his/her own behavior.

L. Let all children share responsibility.
Don't try to fault-find or find the guilty party.
All share the responsibility.
All decide how to handle problem.
No tattling or splitting.

V Steps in Applying Natural and Logical Consequences, Role Play, Typical Family Problems

Ask parents for problems in their family. See if group can help suggest different approaches using natural/logical consequences.

VI Worksheet: Engaging a Child's Cooperation

If time, do in group; if not, use as practice

sheet for parents to take home.

VII Parent Handouts

A. Quick Reminders for Effective Communication

B. Four Mistaken Goals of Behavior

C. Four Goals of Positive Behavior

D. Supplemental Reading: Children: The Challenge by Rudolph Dreikurs

APPENDIX O

HANDOUT: GOALS OF MISBEHAVIOR

GOALS OF MISBEHAVIOR

To determine your child's goal, you must check your feelings and the child's response to your attempts to correct him/her. Goal identification is simplified by observing (1) your own feelings and reaction to child's misbehavior and (2) child's response to your attempts at correction. By considering your situation in terms of the chart, you will be able to identify the goal of the misbehavior.

Child's Faulty Belief	Child's Goal	Parents' Feelings and Reaction	Child's Response to Parents' Attempts at Correction	Alternatives for Parents
I belong only when I am being noticed or served.	Attention	Feeling: Annoyed. Reaction: Tendency to remind and coax.	Temporarily stops misbehavior. Later resumes same behavior or disturbs in another way.	Ignore misbehavior when possible. Give attention for positive behavior when child is not making a bid for it. Avoid undue service. Realize that reminding, punishing, rewarding, coaxing, and service are undue attention.
I belong only when I am in control or am boss or when I am proving no one can boss me!	Power	Feeling: Angry; provoked; as if one's authority is threatened. Reaction: Tendency to fight or to give in.	Active- or passive-aggressive misbehavior is intensified or child submits with "defiant compliance".	Withdraw from conflict. Help child see how to use power constructively by appealing for child's help and enlisting cooperation. Realize that fighting or giving in only increases child's desire for powe
I belong only by hurting others as I feel hurt. I cannot be loved.	Revenge	Feeling: Deeply hurt. Reaction: Tendency to retaliate and get even.	Seeks further revenge by intensifying misbehavior or by choosing another weapon.	Avoid feeling hurt. Avoid punishment and retaliation. Built trusting relationship. Convince child he/she is lovab
I belong only by convincing others not to expect anything from me. I am unable. I am helpless.	Display of Inadequacy	Feeling: Despair; hopelessness "I give up". Reaction: Tendency to agree with child that nothing can be done.	Passively responds or fails to respond to whatever is done. Shows no improvement.	Stop all criticism. Encourage any positive attempt, no matt how small. Focus on assets. Above all, don't be hooked int pity. And don't give up.

APPENDIX P

HANDOUT: GOALS OF POSITIVE BEHAVIOR

GOALS OF POSITIVE BEHAVIOR

CHILD'S BELIEF	GOAL	BEHAVIOR	HOW TO ENCOURAGE POSITIVE GOALS
I belong by contributing.	Attention. Involvement. Contribution.	Helps. Volunteers	Let child know the contribution counts and that you appreciate it.
I can decide and be responsible for my behavior.	Power. Autonomy. Responsibility for own behavior.	Shows self-discipline. Does own work. Is resourceful.	Encourage child's decision-making. Let child experience both positive and negative outcomes. Express confidence in child.
I am interested in cooperating.	Justice. Fairness.	Returns kindness for hurt. Ignores belittling comments.	Let child know you appreciate his/her interest in cooperating.
I can decide to withdraw from conflict.	Withdrawal from conflict. Refusal to fight. Acceptance of others' opinions.	Ignores provocations. Withdraws from power contest to decide own behavior.	Recognize child's effort to act mature.

APPENDIX Q

HANDOUT: ENGAGING A CHILD'S COOPERATION

APPENDIX Q

ENGAGING A CHILD'S COOPERATION

1. Describe what you see or describe the problem: "There's a wet towel on the bed."

2. Give information: "The towel is getting my blanket wet."

3. Say it with a word: "The towel."

4. Describe what you feel: "I don't like sleeping in a wet bed."

5. Write a note (above towel rack): "Please put me back so I can dry. Thanks! Your Towel."

Write a statement that shows how each of the skills listed above could be used to invite your child's cooperation.

A. Four-year-old John is very aggressive and wants to be in control. You have observed him fighting and Mark reports he was scratched.

1. DESCRIBE (what you see or describe the problem): _____

_____

_____

2. GIVE INFORMATION: _____

_____

_____

3. TALK ABOUT YOUR FEELINGS: _____

_____

_____

4. SAY IT WITH A WORD: _____

_____

_____

5. WRITE A NOTE: _____

_____

_____

B. You are about to wrap a package and can't find your scissors. Your child has a pair of scissors, but is constantly borrowing yours and not returning them.

1. DESCRIBE: _____

_____

_____

2. GIVE INFORMATION: _____

_____

_____

3. TALK ABOUT YOUR FEELINGS: _____

_____

_____

4. SAY IT WITH A WORD: _____

_____

_____

5. WRITE A NOTE: _____

_____

_____

C. Sam constantly takes his brother's supplies, although he has supplies of his own. He has just taken his brother's crayons.

1. DESCRIBE: _____

Engaging a Child's Cooperation

_____

_____

2. GIVE INFORMATION: _____

_____

_____

3. TALK ABOUT YOUR FEELINGS: _____

_____

_____

4. SAY IT WITH A WORD: _____

_____

_____

5. WRITE A NOTE: _____

_____

_____

APPENDIX R

HANDOUT: QUICK REMINDERS FOR EFFECTIVE COMMUNICATION WITH CHILDREN

APPENDIX R

QUICK REMINDERS FOR EFFECTIVE COMMUNICATION WITH CHILDREN

Helping Children Deal with their Feelings

1. You can listen quietly and attentively.
2. You can acknowledge their feelings with a word: "Oh", "Mmm", "I see".
3. You can give the feeling a name: "That sound's frustrating!"
4. You can give the child his wishes in fantasy; "I wish I could make the banana ripe for you right now!"

Children need to have their feelings accepted and respected. All feelings can be accepted. Certain actions must be limited: "I can see how angry you are at your brother. Tell him what you want with words - not fists."

Instead of Punishment

1. Express your feelings strongly - without attacking character: "I'm furious that my new saw was left outside to rust!"
2. State your expectations: "I expect my tools to be returned after they've been borrowed."
3. Show the child how to make amends. "What this saw needs now is a little steel wool and a lot of elbow grease."
4. Give your child a choice: "You can borrow my tools and return them or you can give up the privilege of using them. You decide."
5. Take action: Child: "Why is the toolbox locked?" Father: "You tell me why."
6. Problem-solve: "What can we work out so that you can use my tools when you need them and so that I'll be sure they're there when I need them?"

How to Problem-Solve

Step 1:	Talk about the child's feelings and needs.
Step 2:	Talk about your feelings and needs.
Step 3:	Brainstorm together to find a mutually agreeable solution.
Step 4:	Write down all ideas - without evaluating.
Step 5:	Decide which suggestions you like, which you don't like, and which you plan to follow through on.

Quick Reminders for Effective Communication with Children

Alternatives to Punishment

1. Point out a way to be helpful.
2. Express strong disapproval - without attacking character.
3. State your expectations.
4. Show your child how to make amends.
5. Give a choice.
6. Take action.
7. Allow child to experience the consequences of his misbehavior.

Encouraging Autonomy

1. Let children make choices: "Are you in the mood for your gray pants today or your red pants?"
2. Show respect for child's struggle: "A jar can be hard to open. Sometimes it helps if you tap the side of the lid with a spoon."
3. Don't ask too many questions: "Glad to see you. Welcome home."
4. Don't rush to answer questions: "That's an interesting question. What do you think?"
5. Encourage child to use sources outside the home: "Maybe the pet-shop owner would have a suggestion."
6. Don't take away hope: "So you're thinking of trying out for the play. That should be an experience."

Praise and Self-Esteem

1. Describe what you see: "I see a clean floor, a smooth bed, and books neatly lined up on the shelf."
2. Describe what you feel: "It's a pleasure to walk into this room!"
3. Sum up child's praiseworthy behavior with a word. "You sorted out your pencils, crayons, and pens, and put them in separate boxes. That's what I call organization!"

Instead of Evaluating, Describe

APPENDIX S

SESSION VI: THE USE OF TIME-OUT AND BEHAVIORAL CONTRACTS

APPENDIX S

CURRICULUM FOR EXTRAFAMILIAL SEXUAL-ABUSE PARENT PROGRAM

SESSION 6
15 Oct 86
7:30-9:30 p.m.

Use of Time-Out and Behavioral Contracts
Limit Setting

I Limit Setting: The Application of Natural and Logical Consequences

A. Provide choices.
Choices/Alternatives are essential in the use of logical consequences.
Parents provide alternative and child chooses. (Parent must accept child's decision.)
Tone of voice essential and must respect an attitude of respect.
Acceptance and good will.
Example: Page 77.

B. As you follow through with consequence, give assurance that there will be an opportunity to change behavior later.
Children will test the limits.
Tell them decision stands; they can try again later.
Example:

C. If the misbehavior is repeated, extend the time that must elapse before the child may try again.
State opportunity to try again and state the time when the child may try again.
Example:

D. Use a friendly tone of voice which expresses good will.

E. Make sure the consequence is logically related to the misbehavior.
No matter how logical an action may seem, if your tone is harsh and your attitude overbearing and your demands absolute, it is punishment.
Practice situations: Page 81.

Curriculum for Extrafamilial Sexual-Abuse Parent Program

II Use of Time-Out

Handout: "Using Time-Out for Behavioral Problems with Parents"
Especially review page 4, "Things to Check When Time-Out Does Not Work"

III Setting Up Charts and Behaviorial Contracts

A. Define problem.
B. Baseline/Observation.
C. Specify goal.
D. Set up program.
E. Explain to child new procedure.
F. Implementation of program.
G. Reinforcement: Positive and Negative.

IV Handout: Two samples of Behavorial Contracts

APPENDIX T

HANDOUT: USING TIME-OUT FOR BEHAVIORAL PROBLEMS

APPENDIX T

USING TIME-OUT FOR BEHAVIORAL PROBLEMS

Guidelines for Parents

Time-out involves placing your child on a chair for a short period of time following the occurrence of an unacceptable behavior. This procedure has been effective in reducing problem behaviors such as tantrums, hitting, biting, failure to follow directions, leaving the yard without permission, etc. Parents have found time-out works better than spanking, yelling, or threatening. It is most appropriate for children from 18 months through 10 years. Time-out is a relatively mild form of punishment and works best early in the behavior chain.

A. Preparations:

1. You should purchase a small kitchen timer.

2. A place for time-out should be selected. This could be a chair in the hallway, kitchen, or corner of a room. It needs to be a dull place (not your child's bedroom) where the child cannot view T.V. or play with toys. It should not be a dark, scary, or dangerous place. The aim is to remove the child to a place where not much is happening - not to make the child afraid. The bathroom is often the best place. (If child uses water, apply natural consequence, i.e., child cleans up bathroom.)

3. You should discuss with your spouse whih behaviors will result in time-out. Consistency is very important.

B. Practicing:

1. Before using time-out for discipline, you should practice using it with your child at a pleasant time.

2. Tell your child there are two rules when in time-out:

Rule 1: The time will start when he is quiet. Ask your child what would happen if he talks or makes noises when in time-out. The child should say the timer will be reset, or something similar. If he does not say this, remind him of the rule.

Rule 2: If he gets off the chair before the timer rings, you will give him one hard spank and replace him in the chair. Ask your child if he wants to get off the chair and get one hard

spank to learn this rule. Children will usually decline this offer.

3. After explaining the rules and checking out your child's understanding of the rules, go through the steps under C. Tell your child you are "pretending" this time.

4. Mention to your child you will be using this technique instead of spanking, yelling, or threatening. Most kids are pleased to learn this.

C. Procedure:

Step 1: Following an inappropriate behavior, say to the child, "Oh, you...(describe what he did)". For example, "You hit your sister. Go to time-out, please." Say this calmly and only once. It is important not to lose your temper or begin nagging. If your child has problems getting to the chair quickly, guide him with as little effort as needed. This can range from leading the child part way by the hand to carrying child to the chair. If you have to carry child to chair, be sure to hold child facing away from you so he doesn't confuse a hug with a trip to time-out. Don't nag, scold, or scream. Do not debate. Be firm. Ignore side-tracking. Add avoidance situation if child refuses to go: "If you don't go to time-out, no T.V. tonight".

Step 2: When your child is on the chair and quiet, set the time for a specific number of minutes. The rule of thumb is: one minute for each year of age up to five minutes. A 2-year-old should have 2 minutes, 3-year-old 3 minutes, etc. For children 5 years and over, five minutes is the maximum amount of time. If your child makes noises, screams, or cries, reset the timer. Do this each time the child makes any noises. If your child gets off the chair before the time is up, give him one hard spank on the bottom, replace child in chair, and reset timer. Do this each time child gets off chair. If these procedures are followed carefully, spankings will rarely be necessary after about three days. Five minutes is as effective as 20-30 minutes.

Step 3: After your child has been quiet and seated for the required time, the timer will ring. Go to the time-out chair and ask your child if he would like to get up. Do not speak across the room. A nod of the head or a positive or neutral answer is required. Answering in an angry tone of voice or refusing to answer is not acceptable. If your child is still

angry, he will probably get into trouble again in a short while. Should your child answer in an angry tone or refuse to answer, reset the timer, it must go to the full time. You are the one who should decide when your child gets off the time-out chair - not your child.

Step 4: As soon as your child is off the time-out chair, you should ask if he wishes to repeat the behavior which led him there in the first place. For example: "Would you like to hit your sister again so I can put you in time-out and then you will learn the rule?" Generally, children say "No" or shake their heads. You can then say, "I'm happy you don't want to hit your sister." If your child should take you up on this offer and repeat the unacceptable behavior, calmly place him in time-out. Although this may sound like you are daring your child to misbehave, it is better if he repeats the behavior in your presence. That way, your child will have several opportunities to learn that unacceptable behavior results in time-out.

Step 5: After your child finishes a time-out period, he should start with a "clean slate". It is not necessary to discuss, remind, or nag about what the child did wrong. Within five minutes after time-out, look for and praise good behavior. It would be wise to take your child to a different part of the house and start him in a new activity. Remember: Catch 'em being good.

D. Summary of the Rules:

1. For Parents:

Decide about behaviors you will use time-out for ahead of time. Discuss these with your child.

Don't lead your child in time-out and forget about him.

Don't nag, scold, or talk to your child when he is in time-out. All family members must follow this rule.

Remain calm, particularly when your child is being testy.

You may see an increase in acting-out behavior before it decreases. Don't panic.

Using Time-Out for Behavioral Problems

2. For Children:

Go immediately to time-out when you're asked to. Don't argue.

Remain quiet and stay on the time-out chair until you're asked to get down. You'll spend less time that way.

The timer is not to be touched by any child in the house. If you do touch it, you will be placed in time-out.

3. Brothers and Sisters:

If you tease, laugh at, or talk with your brother or sister while he/she is in time-out, you will be placed on the chair and your brother or sister will get down.

(See attached Things to Check When Time-Out Does Not Work)

Things to Check When Time-Out Does Not Work

1. Be sure you are not warning your child one or more times before sending him/her to the time-out chair. Warnings only teach the child that he/she can misbehave at least once (or more) before you'll use time-out. Warnings only make things worse - not better.

2. All adults who are responsible for disciplining your child at home should be using the time-out chair. You should agree when and for what behaviors to send your child to time-out. (You will want new sitters, visiting friends, and relatives to read and discuss the time-out guidelines.)

3. In order to maximize the effectiveness of time-out, you must make the rest of the day (time-in) pleasant for your child. Remember to let your child know when he/she is well-behaved (catch 'em when they're good) rather than taking a good behavior for granted. Most children would prefer to have you put them in time-out than to ignore them completely.

4. Your child may say, "Going to the chair doesn't bother me" or "I like time-out". Don't fall for that trick. Many children try to convince their parents that time-out is fun and therefore not working. You should notice over time that the problem behaviors for which you use time-out occur less often. (Time-out is not supposed to be a miserable experience.)

5. When you first begin using time-out, your child may act as though time-out is a game. He/She may put him/herself in time-out or ask to go to time-out. If this happens, give your child what he/she wants: put him/her in time-out and require the child to sit quietly for the required time. Your child will soon learn it is not a game. Your child may also laugh or giggle when being placed in time-out or while in time-out. Although this may aggravate you, it is important for you to completely <u>ignore</u> your child when he/she is in time-out.

6. You may feel the need to punish your child for doing something inappropriate in the chair (such as cursing or spitting). However, it is very important to ignore your child when he/she misbehaves badly in time-out. This will teach your child that such attention-getting strategies will not work. If your child curses when out of the chair (and it bothers you), be sure to put child in time-out.

7. Television, radio, or a nice view out of the window can make time-out more tolerable and prolong the length of time your child

must stay in the chair by encouraging him/her to talk. Try to minimize such distractions.

8. You must use time-out for major as well as minor behavioral problems. Parents have a tendency to feel that time-out is not enough punishment for big things and thereby discipline inconsistently. Consistency is more important for time-out to work for big and small problems.

9. Be certain that your child is aware of the rules that, if broken, result in time-out. Frequently parents will establish a new rule (e.g., "Don't touch the new stereo") without telling their children. When their children break the rule, they don't understand why they are being put in time-out.

10. Review the time-out guidelines to make certain you are following the recommendations. If your child is getting off the chair frequently, be sure to give one swat on the bottom and place child back on chair without talking.

11. When your child is in time-out, don't:

Look at him
Talk to him
Talk about him
Act angry
Stay in room

Do:

Remain calm
Follow written guidelines
Find something to do (read magazine, etc., when child is talking or crying in time-out)

APPENDIX U

HANDOUT: BEHAVIORAL CONTRACT

APPENDIX U

BEHAVIORAL CONTRACT

Name _____ Date _____

Behavior/Chores (possible points): S M T W T F S Total Points

_____

_____

_____

_____

_____

_____

_____

_____

Consequences: Fines/Punishments:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____

Payday: _____

Signed: _____ _____

_____ _____

APPENDIX V

HANDOUT: BEHAVIORAL CONTRACT (JOINT)

APPENDIX V

BEHAVIORAL CONTRACT
(Best done in conjunction with child and both parents)

1. Define problem:

2. Specify goals (define target behavior):

3. Procedure:

4. Positive Consequences:

5. Negative consequences:

_____ Date begun: _____
Dad's signature

_____ Date reviewed: _____
Mom's signature

_____ Date ended: _____
Child's signature

APPENDIX W

SESSION VII: PROTECTING YOUR CHILD

APPENDIX W

CURRICULUM FOR EXTRAFAMILIAL SEXUAL-ABUSE PARENT PROGRAM

SESSION 7
22 Oct 1986
7:30-9:30 p.m.

Protecting Your Child

I This follows outline form from book, Laura M. Huchton, PROTECT YOUR CHILD (Englewood Cliffs, N.J., Prentice-Hall, Inc., 1985) Permission obtained.

Following is a list of specific safety topics recommended for parents:

A. Stranger Awareness

A stranger is anyone your child or your family doesn't know well. By age four, a child can generally understand the concept of a stranger.

A stranger can be: male or female; young or old; well-dressed and drive a nice automobile or a van or a truck; can be dirty and poorly-dressed and drive an old car, van, or truck.

Children should never be involved with strangers in any way.

Children should never accept rides with anyone, even a friend, unless given direct parental permission. Just because you know someone doesn't mean you're safe with that person.

There are good stranger and bad strangers, but children cannot tell the difference.

B. Safety Away From Home

1. Malls

The larger the place, the less control of circumstances; therefore, you need to have more control of your children.

Take only a few children, not a large group.

Keep your hands on your children. (Take them into the dressing room, bathroom, etc.)

Don't become distracted by window-shopping or meeting a friend and talking. Keep your eyes on your children. Don't ask clerks or anyone else to babysit your child while you shop.

Don't let a child go to a video arcade alone. Often video arcades are places for pimps, pushers, pornographers.

2. Mall Game

Ask your child to pick five people they'd go to if they were lost.

Take your child and show them who you prefer.

Point out tagged, uniformed security guards.

Introduce them to your child.

Ask them what they do to help a lost child.

Review what you'd expect of your child if they became lost.

C. Car Safety

Don't leave a child alone in the car, no matter what, and no matter the length of time.

Any serious assailant can trick a child into opening up a locked car.

D. Supermarket

Don't allow children to speak to strangers, even if they pay special compliments to you or your child.

Don't turn your back on your child for any reason.

Never send a child to get an item you forget to pick up.

Take only as many children as you can safely keep your hands on.

Buy them a bakery cookie or something to occupy their time and keep them from wandering.

Never send a bored child alone to the toy department or anywhere else.

Be sure the children are seated safely in the grocery cart.

Don't allow children to walk more than three feet away from you.

Don't leave your child in the basket at the checkout stand while you go back to pick up a forgotten item. Store clerks cannot be responsible for the safety of your child.

If need be, find a reliable baby sitter on shopping days and go shopping alone.

E. School

Know exactly the path your child walks to and from school.

Point out offices or houses the child could run into for help and practice that

with your child.

Make sure school has absentee reporting. Parents of children who are not in school have the right to know immediately.

Encourage a fingerprinting program at your school.

Don't give blanket permission for field trips. You must know where your child is at all times.

If you say no to a field trip, what provisions are made for that child at school.

Know your child's teachers and coaches. Often the perpetrator is someone who is skilled in and comfortable working with and among children.

Find out who the chaperones are on field trips. Should be faculty members, other children's parents.

Attend after-school activities your child is in. If not, see if another parent or friend, or hire a babysitter, to go watch your child. Boy Scout and Girl Scout overnight campouts need to be checked.

Accompany your child, if you can and find out what provisions are made for one to be a chaperone.

F. Religious Meetings

Make sure you've taught your child that after Sunday school they are to stay with their teacher until teacher escorts them to the car or a place for a prearranged pickup.

Make sure that you know who your child's

Sunday school teacher, any youth-activity directors are.

Make surprise visits to the class.

If you have a child in the nursery, make sure the nursery workers are competent. Check their backgrounds with the church, supervisors or professional organizations.

Never leave a baby or child in a poorly-equipped or dirty nursery. This is an instant indication of poor care.

Be sure the nursery is on the checklist to be inspected by church or synagogue authorities.

Again, make surprise visits to nursery class.

If you have any doubts about leaving your child in the care of any religious teacher, religious person, any nursery attendant, don't do it.

Report any and all incidents that attest to poor care on the part of the staff to appropriate supervisor.

Don't allow your children on the church or synagogue parking lot or anywhere outside without you.

You can volunteer to help ease the burden at any nursery, Sunday school, religious school programs.

G. Public Restrooms

If possible, always accompany your child to the public restroom. If the boy is too old to come into the ladies room, then the mother should stand outside the men's

restroom, waiting for him.

Fathers can knock on the door of the ladies restroom to make sure it's clear before taking their daughters inside.

If a child goes unaccompanied to a restroom and they haven't returned, go to check, call their name. If they do not answer, immediately go on in to make certain that all is well.

Store managers, restaurant owners, any staff will be happy if you feel that your child doesn't want you coming in checking on him and you're not feeling secure, ask one of them to go in and do it.

H. Public Swimming Pools

Pedophiles are attracted to places where children congregate, so make sure you follow the simple rules:

1. Lifeguards are not babysitters. It's not their job.

2. Again talk to your child about the potential of dangers in dressingrooms.

3. Accompany your child, if possible. If not, make sure that a trusted friend, family member, or minimally another child is with them.

4. Watch to see if you see a stranger who may seem inappropriate or out of place.

I. Parks and Playgrounds

These are places that are never supervised and therefore are perfect places for sexual offenders to wait for unaccompanied and unsupervised children.

If you can't accompany your child, have a responsible adult do so.

Don't allow child to enter a park, playground, restroom alone. Any adult whom you trust should take the child.

Make sure that children do not wander. Parents should stay with their child's chosen play area.

J. Drive-In/Walk/In Movies

Make sure that children are accompanied to movie theaters. If not, make sure another parent goes or a responsible older child or young adult.

Follow the same rules for public restrooms to teach your child in this setting that there are ushers, managers, ticket sellers to report incidences to.

Warn your child that candy, food bribes, and soda to leave the theater by the back exit can be given and make sure they're alert to this potential danger.

Teach your child to scream and run for help if he/she is molested or approached by stranger in any public place.

K. Doctor's Office, Emergency Room, or Hospital

Make sure when you go to a doctor's office that there's always a parent who remains with the child at all times.

You have a right to question all procedures and require a full explanation from the doctor about his medical choice of treatment.

If you're concerned about medication, you

have a right to question the doctor.

You can refuse any treatment or medication but don't act hastily; remember that a qualified doctor should know the proper procedures to follow in order to help your child.

L. Parent-Child Distress Words

This is an emergency distress word that can be agreed upon by parents and child. This can be the name of an unusual animal, toy, whatever.
Remind your child that this is a secret between you and your parents and it could be used to save their life; that children can use the distress word to indicate whether they trust or do not trust someone.

Make sure that in case of distress words in any situation where you've left the child and you call back to check on the child, do not accept that person's testimony but insist upon talking to the child. Remember: talk to your child - not the babysitter.

Explain to your child ahead of time that, if he feels frightened or in danger, he should use a distress word.

If he puts it into his conversation, verify it easily by asking him if he's in trouble.

If he answers affirmatively, hang up and get home as fast as you can.

If you feel there is a real possibility of danger and can't get home fast enough, call the police.

Be patient if your child misuses his

distress word at first.

M. Answering the Door

Teach your child to answer a knock on the door with caution. Set safety rules and have them followed when answering the door.

Police suggest children who are left at home alone or with a babysitter not answer a knock on the door.

Parents must decide exactly what instructions they want the children to follow if the knocker persists, if the knocker persists and then goes away and returns, if the knocker claims to be in distress and needs to use the telephone, if the knocker is a friend who's an unexpected caller, if the knocker tries to carry on a conversation with the child through the door.

The best answer is that children are not allowed to answer the door; no one is allowed in the home - it matters not who it is.

N. Answering the Telephone

Again it is imperative to tell the child never to announce that the child is home alone or home alone with a babysitter. You must point out to reinforce it that it matters not who is on the other end of the phone; everybody has to be treated the same.

The response is, if someone asks to talk to mom or dad, "My parents can't come to the phone right now. They asked me to take a message. They will call you in a few minutes. What is your name and phone number?"

Curriculum for Extrafamilial Sexual-Abuse Parent Program

O. Choosing the Right Babysitter

This is a very important and difficult subject. Following are some points that might be helpful:

Choose among trusted family members first.

Choose from trusted friends, perferably those with children.

Make reciprocal agreements to trade babysitting time with close friends.

Friends who have had excellent baby-sitters can recommend them to you, but still check out other references.

Never leave your child with a stranger. Prepare to take your child with you.

If you have no other choice, be sure to check at least five references and any state registration the babysitter may have.

You can ask neighbors for extra references. You can check with the Child Welfare or police department to see if there have been any reports of misconduct with a child on the part of the sitter.

You could start a babysitting co-op.

When you leave your child at home, call regularly to check on him.

Be sure that your child knows to use the distress word.

Beware of babysitters who won't let your child come to the phone. Do not accept any excuse; insist upon talking to your child. If you're not allowed to speak with your child, return home at once and

call a neighbor or the police to give a quick check on your child while you're on the way home.

Don't forget to provide the babysitter a complete list of emergency phone numbers, safety rules, family friends, doctors, etc.

P. Yard Safety

Children are not safe in their own yards. Certainly a barking dog, the bigger the better, is a good preventative to crime of any kind.

Children again are instructed not to talk to anyone.

If possible, parent is present in the yard at all times with younger children.

Don't leave yard without parental permission.

Check on children frequently.

Have children report in frequently.

Never speak to stranger.

If stranger talks, instruct children to run in house (gather younger siblings).

Visiting children follow your rules.

Make sure visiting children have parental permission and when they are expected home.

Visiting children should be accompanied home by a parent - you or theirs.

Supplemental Reading: Huchton, L. (1985) Protect Your Child: A Parent's Safeguard Against Child Abduction and Sexual Abuse. Englewood Cliffs: Prentice-Hall.

APPENDIX X

SESSION VIII: THE FINAL SESSION

APPENDIX X

SESSION VIII: THE FINAL SESSION

October 29, 1986

7:30 - 9:30 p.m.

I Complete curriculum from Session VII: Protecting Your Child.

II Question and Answer by parents/review of any topics

- Make sure parents have opportunity to review any material they are unclear about.

- Allow opportunity to discuss any issues parents felt were not covered in course.

III Parents discussion about involvement in Parent Program - what did it mean to them.

IV Have parents complete Parent Program Assessment and Evaluation form.

V Future plans of group

- Attempt to get parents involved in a positive direction, i.e., volunteers in local advocacy programs.

APPENDIX Y

PARENT PROGRAM ASSESSMENT AND EVALUATION FORM

APPENDIX Y

PARENT PROGRAM ASSESSMENT AND EVALUATION FORM

Date _____

Please take a few minutes to complete this form. Your assistance is needed to improve the planning and implementation of future parent programs. Thank you.

****

1. In general, how would you rate the program? Excellent ____ Good ___ Fair ___ Poor ____

2. Was the material covered relevant to you? Yes ___ No ____

3. What new topics should be added to future programs? _____

_____

_____

4. Please indicate how well you feel the objectives of this program were satisfied? Excellent ____ Good _____ Fair ____ Poor ____

5. What changes would you recommend in the physical facilities, arrangements, schedules, length of program, time of year, etc.?

_____

_____

_____

6. Do you feel that you have increased your knowledge of child sexual abuse? Yes ___ No ___

7. Do you feel that you now know behavioral indicators of child sexual abuse? Yes ___ No ___

8. Do you feel that you now understand the effects of child sexual abuse on the child/parent/family? Yes ___ No ___

9. Have you had an opportunity to express your feelings about your child's sexual abuse? Yes ___ No ___

Parent Program Assessment and Evaluation Form

10. Have you learned new methods of parenting your children? Yes ___ No ___

11. Do you feel more competent now in handling the sexual-abuse problem? Yes ___ No ___

12. Has this group helped decrease the sense of being alone as the parent of a child who has been sexually abused? Yes ___ No ___

13. Has this group helped reduce your stress as the parent of a sexually-abused child? Yes ___ No ___

14. Have these sessions helped you as a parent? Yes ___ No ___

    In what ways? _____

    _____

    _____

    _____

15. Have these sessions helped you as a spouse? Yes ___ No ___

    In what ways? _____

    _____

    _____

    _____

16. Have you noticed any behavioral changes in your sexually-abused child because of the knowledge gained by your participation in the Parent Program? Yes ___ No ___

    What type changes? _____

    _____

    _____

    _____

Parent Program Assessment and Evaluation Form

17. Would you be interested in attending future Parent Programs?
    Yes ___ No ___

18. Have you benefited by your participation in this Parent Program? Yes ___ No ___

19. What has benefited you the most? _____

    _____

    _____

    _____

    _____

20. Comments:

APPENDIX Z

LETTER OF REQUEST TO PRENTICE-HALL, INC.

APPENDIX Z

12 September 1986

Prentice-Hall, Inc.
General Publishing Division
Englewood Cliffs, New Jersey 07632

Gentlemen:

I hereby request permission to reproduce and use copies of the outline in Chapter 1 and "What Every Parent Should Know" in Chapter 8 from Protect Your Child by Laura M. Huchton, copyright 1985.

As part of the studies for my doctorate degree, I am conducting an eight-week course for parents of sexually-abused children. The above-referenced items would be most helpful and invaluable to include in this course.

I would greatly appreciate a prompt reply.

Thank you very much for your time and attention.

Sincerely,

Barbara S. Bernbaum, M.A.

BSB/dl

APPENDIX AA

LETTER OF PERMISSION FROM PRENTICE-HALL, INC.

APPENDIX AA

Prentice-Hall, Inc.
Englewood Cliffs, N.J. 07632

(201) 592-2629
Telex No. 13-6423

September 18, 1986

Barbara S. Bernbaum, M.A.
Psychiatric Associates of Mid-Florida
1270 Minnesota Avenue, Suite 200
Winter Park, Florida 32789

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Alice Corring

Alice Corring
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AC/bg